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MENTAL HYGIENE

MENTAL HYGIENE aims to bring dependable information to everyone interested in mental problems. Here are original papers by writers of authority, reviews of important books, reports of surveys, special investigations and new methods of prevention and treatment in the broad field of mental hygiene and psychopathology. Our aim is to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials and students of social problems find it of special value.

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Articles

Book Reviews

JULES HENRY, PH.D.

Cultural change and mental health

When we look at a frank and objective description of another culture we sometimes ask ourselves, "How do people ever manage to live in it?" Whether it be strife-torn Greece or Rome, the humiliating misery of the Chukchee of Siberia or the degradation of the slums of Dicken's London, the question is often, "How did people manage to live in it?" And the implied second question is, "Without going mad?" To these questions anthropology returns the answer that people live in it because they have no place else to go, and that though populations do not become psychotic they do suffer severely emotionally.

In the anxious and impulse-ridden America of today, then, the issue for mental health as a public health problem is not so much the treatment of diagnosed cases, but rather the prophylaxis of mass suffering.

In contemporary America no program of mental health can ignore the following facts: (1) the rapid growth of industry, population and metropolitan regions; (2) the increased use of automation; (3) the shift from superego to id-values. Since this is a forum devoted to exploring the causes and control of mental illness I shall devote no time to the cheerier aspects of the three facts but concentrate rather on their darker side.

Among the consequences of the growth of industry which are relevant to mental health are the following: (1) increasing pressure on small business; (2) increasing masses of anonymous workers; (3) destruction of

Dr. Henry, who is professor of anthropology at Washington University in St. Louis, presented this paper March 20, 1957 at the National Health Forum in Cincinnati.

the human habitat through industrial land use, stream pollution and exhaustion of water resources; (4) astronomical expenditures for advertising; (5) attraction into the labor force of more and more women; (6) rises in wages and consumer expenditures, sometimes called the rising standard of living, but which, as time passes, becomes a rising standard of luxury; (7) increase in the rate of industrial obsolescence.

These changes have the following effects:

(1) The small business man's struggle to survive becomes harder and he works and worries more and more for small returns. In these circumstances his family must bear the burden of his increasing anxiety.

(2) Since the mass of industrial employees work at jobs in which they feel insignificant and emotionally unrewarded, they plunge into impulse release when they check out. In contemporary America this means making great demands on wife and children for affection, approval and support.

(3) The destruction of the human habitat—the disappearance of wooded areas and stream pollution—deprives people of recreational facilities out of doors and throws them more and more on their own emotional resources and on those of their families and friends.

(4) Expenditures for advertising, estimated at $10,000,000,000 in 1956 and destined to increase rapidly in the future, increase the yearning for consumer goods, travel and commercial recreation, with consequent emphasis on release of impulse in all directions. This is advertising's contribution to the era of the id—of impulse release and fun. Meanwhile the distortion of values introduced into the communications channels by advertising has consequences which must be presumed to be important; otherwise the advertisers would not keep it up.

(5) The attraction of more and more women into the labor force naturally raises important questions in regard to the emotional life of the family. It means that just at that era of our civilization when the family needs her most, mummie is going to be around less. This fact must be confronted, however, not by attempting to turn the clock back but by learning how to handle the new emotional situation. It means specifically that the emotional problems of the family can no longer be largely mother's concern but must be managed by the entire family.

(6) The rise in the standard of living has created a population with a strong drive toward obtaining the symbols of that rising standard: hard goods and a good time. This too has helped usher in the era of the id—of impulse release and fun.

(7) The snowballing increase in the rate of obsolescence of the instruments of technology means a corresponding speeding up of the obsolescence of occupations: the worker trained to one occupational category today has no guarantee that he will not be obsolete five years hence.

In general, the vast changes that are taking place within the structure of American society and economy add to the uncertainty of life and create continuous waves of anxiety.

The growth of our population results in increased crowding and, in an intensely motorized public, will for a long time to come sustain a mounting accident rate. Americans have always been extremely sensitive to crowding and though, as compared to Europeans and Asiatics, they really do not know what crowding is like, they fly at the slightest sign of it. The consequent mobility will bring an even greater disruption in personal life than in the past.

Increase in population is already creating local problems in water supply and waste disposal and in strain on other usually adequate public facilities such as schools, public health systems and police. The flight of population outward from the city brings the social conflicts of the center into the suburbs and brings into suburban communities problems in social stratification that did not exist there previously.

Destruction of the human habitat is a consequence of population expansion as much as it is of industrial expansion, for the necessary homes, schools, roads and service facilities eat up the land. Consequent on this is the disappearance of wooded and other recreational areas and the frantic efforts of outlying municipalities to wall themselves off from change, with a resulting irritation in groups who feel themselves discriminated against.

The growth of metropolitan regions creates administrative problems of a new order, and as the metropolitan areas move toward consolidation their financial burdens increase, with a consequent need to rework the tax structure in order to accommodate new problems. The issue here is that administrative transformation at the metropolitan level changes the character of the administration of health programs, constantly changing *the administrative focus of health* as the region changes. At the same time the rapid growth of suburbs creates budgetary problems they previously did not have. In these circumstances mental health programs easily become stepchildren, and the actual burden of management is thrown upon the family.

Finally, with respect to automation, the simplification and integration of continuous machine operations removes the worker even further from contact with the product on which he works, and in many cases will make it impossible for him even to stay awake at his job, no less become involved in it. Work will become merely a vague sense of nausea, indistinguishable from a hangover.

On the positive side there is the expectation that there will be a great increase in leisure time which will be devoted to intellectual activities. Since, however, the majority even of those in the most favorable circumstances have never devoted themselves to intellectual pursuits, it is unlikely that it will occur now Furthermore, because of the increasing emphasis on the expression of id-impulses and because of tensions brought about by the massive social changes, it is unlikely that much impulse will be sublimated in painting, music, reading and other gentlemanly interests. Rather, one can expect more of a Roman holiday—increased attendance at games, prize-fights, burlesque, movies and TV; more picnics, barbecues and excursions.

Let us stop here a moment to consider the human context of the changes of which I speak. All of them take place among a people who have learned, in a liberal democracy, to expect government to take more and more responsibility for their problems and who will never be satisfied, for dissatisfaction is the essence of American democracy. In a sense the only reason local governments have been able to get away with totally inadequate provision for mental health is the ignorance of the citizens. When the public really learns about mental health—what it means and has meant to them and how they were deprived of help —they will feel they have been cheated.

In view of the fact that I have defined the problem of mental health today as a problem not of cases but of a *chronically suffering population*, what are the measures to be taken to relieve it?

In answer to this question I propose that

beginning at puberty our citizens begin to receive instruction in the handling of each other's problems. The American family is the place where all the tensions generated by social change come to a focus and it is there that the problems must be resolved. We know enough now about emotional suffering to be able to say that it is a family epidemic. In these circumstances, the malady being widespread in a population approaching 200,000,000, its control cannot be handed over to outside agencies but must be treated by the family itself. School children have been taught physical hygiene; they can be educated to understand themselves and one another, which is mental hygiene, so that when they have families they will know what to do. Mental hygiene education must be given by specially trained personnel as part of the school curriculum beginning in junior high school and continuing through high school and into college. The curriculum would include reading, lectures and group discussion. It is the cream of the jest that knowledge of the outer world should be specifically provided for and communicated to children by trained persons while understanding of the inner world is left to chance. We have forgotten Socrates' admonition that the essence of knowledge is self-understanding.

In the past even the best school programs in mental health have been oriented toward case-finding and treatment. The essential issue, however, is that the management of tensions that disrupt life is a population problem and not merely a case problem and must be handled by public health methods that meet the tension at its source and handle the pathogenic vector directly. The place to begin to handle it is where it is—in children, where the necessary compulsion can be used. Public emotional illness is private menace and there is no more reason for making prophylaxis for emotional illness voluntary than there is for making vaccination or sanitary garbage disposal voluntary. Train our children in mental hygiene so that they will grow up to be understanding husbands, wives and parents who will cooperate with one another in the mutual management of family emotional problems. Train our children in human understanding so that America will assume a revolutionary kind of leadership among nations—a leadership of human international understanding. This alone is the true pathway to peace.

SHELDON and ELEANOR GLUECK

Working mothers and delinquency

Among the numerous causal influences to which delinquency has been attributed, that of the absence of the mother from the home in gainful employment has aroused particular interest in current discussions.[1] The proportion of mothers who spend part of their time in outside employment has been increasing rapidly since the two world wars.[2] Today there are several million mothers who go out to work; and with the constant stimulation of high-pressure advertising to transform into urgent necessities the products of the machine and electronic age that have previously been deemed luxuries limited to high-income groups, the common desire to upgrade living standards will no doubt stimulate more and more mothers of young children to supplement the family income by seeking employment outside the home.[3]

Apart from the effect on the working mother herself, what effects will this have on family life, on the rearing of children,[4] on the emotional health of youngsters and, more specifically, on juvenile delinquency?

Thus far there is little more than speculation among social workers, teachers, psychiatrists and journalists on this significant

Sheldon Glueck is Roscoe Pound Professor of Law at Harvard Law School. Eleanor Glueck is research associate at Harvard Law School. They are co-authors of 11 major works on delinquency and crime.

[1] "But going to work raises doubts—in her mind as well as in those of some moralists—as to whether she will be able to combine job and home, and be a good mother. In fact, a whole host of pathologies, from rising delinquency to increasing divorce, is being charged to working women." *Fortune*, 54 (July 1956), 172.

[2] According to a competent recent article, "In 1890 a niggling 4% of the country's married women were in the work force; in 1940 there were only 15%; but by April 1956, 30% of married women held jobs. This development has been recent and swift. During World War II the number of married women at work had barely surpassed the number of single girls who held jobs. By 1955, working wives outnumbered the bachelor girls more than two to one." "The current total is 21 million women workers, or one-third of all persons employed." *Ibid.*, 91.

[3] "There are several elements responsible for this emerging pattern of the behavior of women, espe-

trend in American culture. Where sound and organized factual data are lacking, the winds of opinion can blow in any direction. Thus those psychiatrists who are influenced by the psychoanalytic emphasis on the crucial importance of parent-child relationships during the first three or four years of life in integrating personality and solidifying character view with alarm the growing excursions of young mothers into factory and shop. They are convinced that the economic gain to the family is far too high a price to pay for the loss in the emotional stability of the children. They point to the child's repeated traumatic experiences when again and again his mother, the major source and symbol of his security and love, goes off and leaves him yearningly unsatisfied. They emphasize that it is difficult to find a satisfactory substitute for the natural mother. They speculate that beneath the ostensible economic reason for the mother's leaving the family roof there might in many cases be the deeper motivation of a wish to escape maternal responsibility or a pathologic drive to compete with men.

On the other hand, those who justify the working of mothers claim that a woman who enjoys her activities outside the home is all the more satisfied with her maternal duties when she returns and that she can make up in the quality of love and care what she lacks in quantity. They point to outstanding examples of career women who have reared children successfully while conducting a home of warmth and decency. Such women insist that it is possible to arrange for competent substitute care for the children at times and in areas in which it is not indispensable for the mother to be present; and that the child living under such an arrangement appreciates the mother all the more during the times when she can devote herself wholly to him. In fact, they point out, there are mothers who are by nature not at all suited to motherhood; and the children of such women are better off with substitute parents.

Some persons emphasize that there is a time for mothering and a time for a career. They point out that since child guidance authorities stress the concept that the foundations of personality and character are solidly established by the first few years of life, a wise compromise is possible: ample time can be reserved for the indispensable aspects of motherhood during the crucial years of childhood but thereafter a woman can safely pursue work outside the home.

In all this speculation there is, of course, entangled the fact that among the seriously underprivileged the economics of the situation leave little free choice as to whether the mother should or should not seek outside employment.

The reader will no doubt be able to add to the pros and cons of the question; but

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cially married women, in the labor force. There is the large number of job opportunities that an expanding economy now offers. There is the free time made available by modern household facilities (*e.g.*, ready-cooked meals). Education, now universal, gives many women a vocational urge that homemaking alone cannot satisfy. A job provides stimulus and companionship that the home in daytime does not. (Typical comment of a working wife: 'Now I have something to talk about with my husband when we both come home.') But most significant, perhaps, is the hunger for the appurtenances of a good life that multiple incomes can bring more quickly; the American standard of living has become a built-in automatic 'drive' on the part of the American wife. This asserts itself in her reasons for working." *Ibid.*, 93.

4 ". . . More women with small children are at work than ever before. True, the number is still small, but the rate of increase is astonishing. In 1940 only 7% of mothers with children under five held jobs; by 1955 the number had jumped to 18.2%. (Because of a shift in census techniques, 1955 figure includes 6-year-olds.") *Ibid.*, 91.

the issue remains speculative as long as some factual foundation is not supplied.

The literature of criminology has yielded no definitive studies on this subject. In several of our prior researches we have noted the incidence of employment of mothers of male and female offenders, making comparisons with control materials where these were available. Thus, in *Five Hundred Delinquent Women*,[5] a 5-year follow-up of graduates of the Women's Reformatory in Framingham, Mass., it was noted that over half the mothers of the girls involved in that research worked occasionally.[6] In a relatively comparable period (the early 1920's) only 11.6% of married women in Massachusetts were gainfully employed.[7]

In *One Thousand Juvenile Delinquents* [8] it was pointed out that of the 937 households about which information was available the family income of 389 (41.5%) was supplemented by the outside employment of the mother, this comparing with but 9.9% of married women engaged in gainful occupation during the early 1920's.[9]

In these studies the element of economic status of families was not controlled. However, in a more recent research made in the 1940's, *Unraveling Juvenile Delinquency*,[10] we matched, pair by pair, 500 persistent delinquents with 500 true non-delinquents, not only in respect to general intelligence, ethnico-racial derivation and age but also with regard to residence in culturally and economically underprivileged urban areas. In considering the problem of the working mother in a matched sample of such design we are enabled to hold constant the factor of low economic status (dependency or marginality), thus getting closer to the pure influence of the mother's working, in the complex of traits and forces involved in delinquency.

From the significant fact that three of the five factors most markedly differentiating the 500 delinquents from the 500 non-delinquents encompassed in the Social Prediction Table [11] presented in *Unraveling Juvenile Delinquency (affection of mother for boy, supervision of boy by mother* and *family cohesiveness)* [12] involve the maternal role in the rearing of children, one might reasonably incline to the hypothesis that absence of the mother from the home for lengthy stretches is markedly implicated in

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[5] New York, Alfred A. Knopf, 1934.

[6] *Five Hundred Delinquent Women, op. cit.*, 66–67. About a third were factory hands, another third domestics, the remainder in various other occupations.

[7] However, since this figure includes both married women with children and childless women it is not a perfect control statistic, although highly suggestive.

[8] Cambridge, Harvard University Press, 1934.

[9] Since, however, this figure includes both married women with children and childless women it is not a perfect control statistic, although highly suggestive. Seventeen and a half per cent of the mothers included in *One Thousand Juvenile Delinquents* were factory hands, 47.5% were engaged in various types of domestic work (such as washing or sewing) but remained at home, the remainder were otherwise employed. See *One Thousand Juvenile Delinquents, op. cit.*, 71. See also W. C. Kvaraceus, *Juvenile Delinquency and the School*, New York, World Book Co., 1945, 90. Of 761 cases passing through the Passaic, N. J., Children's Bureau 25% of the white mothers, 44% of the Negro were gainfully employed.

[10] New York, Commonwealth Fund, 1950.

[11] See *Unraveling Juvenile Delinquency, op. cit.*, 261.

[12] *Unraveling Juvenile Delinquency, op. cit.*, 261. The other two factors in this predictive device, which has come to be known in the literature as the Glueck Social Prediction Table, are *discipline of boy by father* and *affection of father for boy.*

the complex of criminogenic influences. Since we had in our files the verified raw materials from *Unraveling Juvenile Delinquency* to test this hypothesis, we have developed the present monograph to meet a growing interest in the subject of working mothers.

METHOD OF ANALYSIS OF DATA

First, what was found in *Unraveling Juvenile Delinquency* regarding working mothers? We reproduce the relevant table:

Usual occupation of mother *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE
	No.	%	*No.*	%	%
Total	496	100.0	497	100.0	–
Housewife	263	53.0	333	67.0	—14.0
Regularly employed	101	20.4	91	18.3	2.1
Occasionally employed	132	26.0	73	14.7	11.9
					$X^2 = 25.72$: $P < .01$

* *Unraveling Juvenile Delinquency*, Table X-9.

It is evident that in the lower economic ranks from which both our delinquents and the control group were drawn a considerable number of mothers, not only of delinquents but also of non-delinquents, were employed either regularly or occasionally. It is further evident that equal proportions of mothers of non-delinquents and of delinquents were regularly employed but that a greater proportion of mothers of delinquents than of non-delinquents worked irregularly.

The types of work engaged in by all the working mothers were cleaning and scrubbing, domestic service by hour or day, factory work, running a store or lodging house (or helping husbands do so), waiting on table, entertaining in cafes and restaurants.

From these initial findings in *Unraveling Juvenile Delinquency* it may be deduced (subject to more definitive information) that more of the children in the families of delinquents than in those of the controls are deprived of necessary maternal care and that this fact has a bearing on the development of delinquency.

In what way does the working mother contribute to the destiny of the child in respect to delinquency?

To answer this crucial question we employ the same correlational and analytic technique developed in our most recently published work, *Physique and Delinquency*,[18] in which a series of tables indicates the relationship between individual psychiatric and psychologic traits and sociocultural factors, on the one hand,

[18] New York, Harper & Brothers, 1956.

TABLE I

Supervision by mother unsuitable *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	%	*No.*	%	*No.*	%
Total	314	63.5	61	12.5	253	51.0
Housewife	126	48.1	23	7.0	103	41.1
Regularly employed	85	84.2	25	28.0	60	56.2
Occasionally employed	103	78.6	13	18.6	90	60.0
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed	.01		.02		–	
Housewife vs. occasionally employed	.01		.10		.05	
Regularly employed vs. occasionally employed	–		–		–	

* *Unraveling Juvenile Delinquency*, Table X-10. The mother, whether in the home or absent from the home, is careless in her supervision in that she leaves the boy to his own devices without guidance or in the care of an irresponsible person.

and physique types and delinquent or non-delinquent behavior, on the other.[14]

To illustrate the method of analysis we present a sample table, in which the factor *unsuitable supervision of boy by mother* is related to the incidence of *housewives* (non-working mothers), *regularly working mothers* and *occasionally employed mothers* among both delinquents and non-delinquents.

The factor involved in this table—*unsuitable supervision of boy by mother*—so markedly differentiates delinquents as a whole from the total control group of non-delinquents (irrespective of whether or not the mother works outside the home) that we had used it as one of five factors in the construction of the social prediction table in *Unraveling Juvenile Delinquency*.[15]

Turning now to an analysis of the illustrative table, we find that it shows, first, that a significantly greater proportion of the mothers of the *non-delinquents* who worked (whether regularly or occasionally) than of those who were housewives neglected to give or provide suitable supervision to their children. Thus entirely apart from the problem of delinquency

[14] For the convenience of those who wish to consult *Unraveling Juvenile Delinquency* we indicate in a footnote to each table here the number of the equivalent table in *Unraveling Juvenile Delinquency*.

[15] For a description of the social prediction table and its validations on various samples of cases, see Eleanor T. Glueck, "Predicting Potential Delinquency: Can It Be Done?" *Federal Probation*, 20 (September 1956).

there is a strong hint that working mothers, at least of low-income groups, are not as conscientious about arranging for the supervision of their children as are those who remain at home. Secondly, the illustrative table shows that supervision of those children who actually became *delinquent* was far less suitable on the part of working mothers (whether they were employed regularly or occasionally) than on the part of the mothers who were housewives. Thirdly, from the column labeled *Difference,* it is learned that a boy who is carelessly supervised and who has a mother who is of the kind who works occasionally is far more likely to become a delinquent than is the poorly supervised son of a mother who does not go out to work.

From now on we shall not advert to the Difference column by name but will rather analyze each table as a whole, drawing from it what we think to be important both in the percentages and in the statistical computations of "significance of difference." The tables themselves are presented in the text to enable the reader to follow our reasoning in each analysis.

The use of computations of significance is familiar to many readers, but for the benefit of those not acquainted with the need of a mathematical discipline to check the reliability of conclusions suggested by inspection of percentile relationships in a correlation table we call attention to the fact that two of the comparisons in the illustrative table have been found to be significant at the .01 "level of confidence," one at the .02 level, one at the .05 level, one at the .10 level. As to the difference in the incidence of unsuitable supervision of the *delinquent* boys by non-working mothers as compared with those regularly or occasionally employed, the divergences were found to be significant at the .01 level; this means that the probabilities are less than one in a hundred that a difference in incidence like the one found between non-working and working mothers of delinquents is not a true association but is due to chance. As to the difference between non-working mothers of *non-delinquents* and mothers who are regularly employed, the divergence was found to be significant at the .02 level, indicating a less than two-in-a-hundred probability that the association found is not a reliable one but attributable to chance. As to the variations in the *Difference* column, the divergences are significant at the .05 level, indicating a special etiologic impact of the already generally criminogenic influence of unsuitable maternal supervision on those youngsters whose mothers were occasional workers as compared with those whose mothers spent their full time at home as housewives.

As pointed out in *Physique and Delinquency,*[16] the line at which the level of statistical significance is drawn is partly a matter of convention and partly suggested by the nature of the materials. The statistical technique used in the present study is the same as that first applied by us to the data in *Physique and Delinquency,* known as the "multiple comparisons" method.[17] This makes it possible not only to determine that variation in the incidence of a factor among two or more categories exists but pinpoints and specifies the locale of the variation. (The interested reader is referred to *Physique and Delinquency,* Chapter II, pages 34 and 35 and Appendix A, in which Prof. Jane Worcester of the Harvard School of Public Health describes the method of multiple comparisons and its implications.) Although in *Physique*

[16] *Op. cit.*

[17] Developed by Prof. John W. Tukey of Princeton University.

PROBABILITY	OBSERVED DISTRIBUTION			EXPECTED DISTRIBUTION
	Delinquents	*Non-delinquents*	*Difference*	
<.01	1	–	–	1.18
<.02	4	1	1	1.18
<.05	9	7	5	3.54
<.10	4	8	2	5.90
<.15	2	6	2	5.90
<.15 and over	98	96	108	100.00
	118	118	118	118.00

The significance level is P=<.05.

and Delinquency the acceptable level of significance was determined by Dr. Worcester to be .01–.10 (with our own very occasional advertence to a comparison at the .15 level because it reflected trends that were consistent with other findings dealing with a related aspect of the subject under analysis), a reliable significance level for the materials included in the present analysis has been found to be .05.[18] In this study, therefore, we have adhered to the .05 level, referring only occasionally to data at the .10 level of significance (for the same reason that we sometimes included a .15 level in *Physique and Delinquency*).

DEFINITION OF TERMS

A word regarding definitions: A mother designated as a *regular* worker is one who has been gainfully employed for all or most of the time since the birth of the particular child included among the cases of *Unraveling Juvenile Delinquency*. She need not necessarily have been on a job from 9 to 5; she may have worked on an afternoon shift or a night shift or for part of the day only. But she has been regularly away from home for several hours a day five to seven days a week, so that her absence is an accepted part of the family routine. An *occasional* worker is one who has been gainfully employed now and then. There has been no fixed pattern in her employment. She has drifted from one job to another with unpredictable frequency, laying off at will and resuming at will. Although it can be surmised that sheer necessity forces some mothers to work regularly in order to supplement an all-too-slender family income, the mother who works sporadically can hardly be looked upon as a "provider" because her earnings cannot regularly be counted upon to prop the family budget.

Perhaps as we proceed with the analysis of the tables some clues will emerge as to the motivations, in addition to the economic, that impel such women to seek occasional jobs.

ORDER OF PRESENTATION OF SIGNIFICANT TABLES

With but one or possibly two exceptions, the factors involved in the series of tables

[18] Calculated by Prof. Jane Worcester of the Harvard School of Public Health.

to be analyzed are etiologically implicated in delinquency *generally* in that, as shown in *Unraveling Juvenile Delinquency,* they do significantly differentiate delinquents from non-delinquents *en masse; i.e.,* irrespective of whether or not the mothers were gainfully employed. The issue in the present monograph is whether the factors in question, though found to be already established as generally criminogenic, exert an *especially heavy impact* on the lives of children of working mothers, the aim being to determine the direct and the indirect relationship between a mother's working and the delinquency of her children.

Those factors in which the statistical analysis has not revealed any difference between working mothers and housewives in relation to the delinquency of children are not adverted to in the text that follows. Such factors are listed in the appendix, however, for the benefit of any readers who may be interested and who may wish to make comparable studies of the role of the working mother in the genesis of juvenile delinquency.

EMOTIONAL DEVELOPMENT OF CHILDREN OF WORKING MOTHERS AS RELATED TO DELINQUENCY

Considering first the relationship of the mother's working to the emotional development of her children, we note that Table II shows that more than half of the *non-delinquents* reared by working mothers were found to be suffering from some specific form of *mental pathology* (marked instability, neuroticism, psychopathy, psychosis), as contrasted with 39% of those whose mothers were not gainfully employed. However, the significance level ($P = <.10$) sug-

TABLE II

Boy has some mental pathology *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	%	*No.*	%	*No.*	%
Total	254	51.6	219	44.4	–	–7.2
Housewife	136	52.1	128	38.8	–	13.3
Regularly employed	51	50.5	49	53.8	–	–3.3
Occasionally employed	67	51.5	42	58.3	–	–6.8
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed		–		<.10		–
Housewife vs. occasionally employed		–		<.10		–
Regularly employed vs. occasionally employed		–		–		–

* *Unraveling Juvenile Delinquency,* Table XVIII-43.

TABLE III

Boy has emotional conflicts *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	%	*No.*	%	*No.*	%
Total	337	74.7	162	37.4	175	37.3
Housewife	174	74.0	115	39.8	59	34.2
Regularly employed	62	66.0	31	37.8	31	28.2
Occasionally employed	101	82.8	16	25.8	85	57.0
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed	–		–		–	
Housewife vs. occasionally employed	–		–		<.05	
Regularly employed vs. occasionally employed	<.05		–		<.05	

* *Unraveling Juvenile Delinquency*, Table XIX-4.

gests caution in relying too heavily on this finding. Since a significant variation in the incidence of mental pathology is not found among the *delinquents* and the differences between delinquents and non-delinquents of non-working and of working mothers are not sufficiently marked to achieve a trustworthy level of significance, it may be concluded that while there is some probability that the absence of a mother from home contributes to the emotional pathology of the children, this pathology apparently does not exert a selective influence on the delinquency of children whose mothers work as compared with those whose mothers are housewives.

As shown by Table III, significant variation does not exist in the incidence of emotional conflicts among *non-delinquents* on the basis of their mothers working or not. Among the *delinquents*, however, those whose mothers worked irregularly are found, to a significantly greater extent than the boys of full-time working mothers, to be burdened with *emotional conflicts*. Thus it may be inferred that, granted the criminogenic influence contributed by emotional conflicts, there occurs an added pressure to delinquency on those conflict-burdened children whose mothers work sporadically. This raises the question of whether or not these irregularly employed mothers are a different "breed" from those who work steadily. Perhaps they are motivated not so much by the need to supplement the family income as by the urge to escape household routines and maternal responsibility. We leave such speculation at this point, taking note as the analysis proceeds of other clues to a possible fundamental difference between the mothers who work

regularly and those who work only occasionally and irregularly, and we turn to the question of deep-seated hostility among children of working and of non-working mothers.

Hostility (determined by the Rorschach test) is the presence of conscious or unconscious hatred against others without a normal reason for it, usually accompanied by a feeling of fear that others are hostile to one. Table IV shows that in the case of *delinquents* hostile attitudes were prevalent among over three-fourths of them regardless of whether the mother worked out or stayed at home. Hence it cannot be said that the fact of the mother's working away from home is alone responsible for the development of hostile attitudes among children and thereby, indirectly, of delinquency. Of course, to the extent that a mother's absence from home in outside employment contributes to the development of hostile attitudes in a boy it is also indirectly contributing to his delinquency, even though there are other reasons for hostility in children than the fact that the mother absents herself from the home.

There is the further indication in Table IV that the incidence of hostility among *non-delinquents* is significantly higher in the case of mothers who work occasionally than in that of mothers who presumably spend their full time in domestic and maternal duties. Here then we have another clue to the possibility that the mother who works only now and then is of a quality different from the steadily employed one, even though this difference need not necessarily be reflected exclusively in a varied effect on the delinquency of her children. It will be seen from Table V that among

TABLE IV

Boy has deep-seated hostility *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	%	*No.*	%	*No.*	%
Total	337	79.7	202	55.8	135	23.9
Housewife	180	80.7	123	49.6	57	31.1
Regularly employed	71	80.7	36	64.3	35	16.4
Occasionally employed	86	76.8	43	74.1	43	2.7
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed	–		–		–	
Housewife vs. occasionally employed	–		<.02		<.05	
Regularly employed vs. occasionally employed	–		–		–	

* *Unraveling Juvenile Delinquency,* Table XVIII-22, Categories: Marked and Slight.

TABLE V

Boy has defensive attitude *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	%	*No.*	%	*No.*	%
Total	243	56.0	187	44.5	56	11.5
Housewife	137	59.8	117	41.9	20	17.9
Regularly employed	38	43.7	41	51.9	—3	—8.2
Occasionally employed	68	57.6	29	46.8	39	10.8
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed	.10		.05		–	
Housewife vs. occasionally employed	–		–		–	
Regularly employed vs. occasionally employed	–		–		–	

* *Unraveling Juvenile Delinquency,* Table XVIII-26, Categories: Marked and Slight.

non-delinquents a significantly higher proportion of boys whose mothers worked regularly outside the home were pathologically defensive than of boys whose mothers spent their full time in domestic duties. Among *delinquents,* however, there is a reverse trend, though of doubtful statistical significance.

SUPERVISION OF CHILDREN BY WORKING MOTHERS AS RELATED TO DELINQUENCY

Turning now to use of leisure time of children as affected by a mother's working, we find that Table VI does not show a significant difference, among *non-delinquents* of working mothers as opposed to non-working mothers, in the extent to which they spent their leisure hours at home. However, a higher proportion of *delinquents* whose mothers were occasional workers occupied their spare time away from home than did the sons of either full-time housewives or of women regularly employed outside the home. Thus the impact of a factor shown in *Unraveling Juvenile Delinquency* to differentiate delinquents from non-delinquents generally is now revealed to exert an especially marked influence on the delinquency of sons of mothers who worked irregularly.

Perhaps we have in this finding another clue to the possibility that mothers who work now and then are more largely animated by a desire to escape household drudgery and family responsibility, with a consequent excessively bad effect on the children. Such youngsters then look for security and affection in companionship

among their peers outside the home. The full-time working mother, on the other hand, appears more likely to provide for the leisure hours of her children in the protected environment of the home.

This is further borne out by Table I, which was presented at the outset by way of illustrating our method of analysis. From this it is obvious that there were significant differences in the incidence of *unsuitable supervisory practices* as between non-working and working mothers; and this is true not only of mothers of delinquents but of those of non-delinquents as well. It would appear that the mothers who worked did not provide as adequately for the supervision of their children as those who were not employed. It is to be kept in mind that these were mothers from families of low-income levels. While inadequate supervision is found to be far more prevalent among the mothers of delinquents than of non-delinquents, it is obvious that the working mother who does not provide proper oversight for her children during her absence from home thereby contributes additionally to their delinquency.

As regards *movie attendance,* it appears to be significantly more excessive among boys already *delinquent* who were the sons of working mothers than among those of mothers who were not gainfully employed. Insofar as the *non-delinquents* are concerned, they as a group attend movies far less frequently than do the delinquents, regardless of whether or not their mothers go out to work. The fact that the mother is occupied outside the home is thus an independent influence which enhances what-

TABLE VI

Boy spends leisure hours away from home *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	*%*	*No.*	*%*	*No.*	*%*
Total	289	58.3	32	6.4	–	51.9
Housewife	151	57.4	26	7.8	–	49.6
Regularly employed	50	49.5	4	4.4	–	45.1
Occasionally employed	88	66.7	2	2.7	–	64.0
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed	–		–		–	
Housewife vs. occasionally employed	–		–		<.10	
Regularly employed vs. occasionally employed	<.05		–		<.05	

* *Unraveling Juvenile Delinquency,* Table XIII-14.

TABLE VII

Boy attends movies three or more times weekly *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	%	*No.*	%	*No.*	%
Total	217	44.7	54	10.9	163	33.8
Housewife	97	38.0	30	9.1	67	28.9
Regularly employed	54	54.0	16	17.6	38	36.4
Occasionally employed	66	50.4	8	11.0	58	39.4
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed	<.05		–		–	
Housewife vs. occasionally employed	<.10		–		–	
Regularly employed vs. occasionally employed	–		–		–	

* *Unraveling Juvenile Delinquency,* Table XIII-12.

ever relationship there may exist between excessive movie attendance and delinquency.

A further effect on the delinquency of children that appears to be related to the mother's working is seen in Table VIII, dealing with the early onset of truancy. Truancy cannot in itself necessarily be regarded as definitively causal of delinquency, for apart from the fact that to some extent it occurs among non-delinquents (*Unraveling Juvenile Delinquency,* Table XII–26) it often follows (or accompanies) delinquency already embarked upon. Nevertheless, as Table VIII shows, *early* truancy either accompanies delinquency in large measure or in some instances reinforces it after previous beginnings of antisocial behavior. It will be seen that avoidance of the routine of school attendance at the age of 10 or less occurred in 60% of all *delinquents,* irrespective of whether or not the mother worked outside the home. However, in the case of delinquents, a higher proportion of sons of occasionally employed mothers were found to become truant in the early school years than sons of mothers who were not gainfully employed or of those who were regular workers. We can again speculate that mothers who work occasionally are primarily motivated by an urge to escape household drudgery and family responsibility and that such mothers have an adverse effect on their children. The child's sense of security is likely to be weakened and his irresponsibility enhanced by the sporadic and unpredictable absence of a mother from the home. In contrast, there is evidence of more adequate and

planful arrangement for the care of the children and for keeping in touch with their school problems by mothers who had the capacity for steady employment.

In regard to the foregoing three factors just analyzed, all of which may be reflective of or associated with the delinquency of children, it can reasonably be concluded that sporadically employed mothers by their own erraticism (as reflected in irregular employment) contribute to or add to the already existing internal or external pressures that make for juvenile delinquency.

WORKING MOTHERS AND INADEQUATE FATHERS AS RELATED TO DELINQUENCY

In the following series of tables we now derive some clue as to the main reasons why the mothers of the boys whose careers were studied in *Unraveling Juvenile Delinquency* sought gainful employment. The reasons appear to center around economic necessity engendered by the irregular employment of their husbands; by separation, divorce, death or desertion of the principal breadwinner; by the incapacity of the husband because of mental illness.

In Table IX we see that, at least as far as the boys studied in *Unraveling Juvenile Delinquency* are concerned, job-seeking by the mothers is related to the *irregular work habits of their husbands.* However, this is not so clearly indicated among the families of the non-delinquents as of the delinquents. Among the latter we see that the poor work habits of the father bear a significant relationship to the irregular employment of the mother, for 73.5% of the delinquent boys whose mothers were sporadic workers also had fathers whose work habits were poor,

TABLE VIII

Boy began to truant at ten or younger *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	%	*No.*	%	*No.*	%
Total	299	60.4	14	2.9	285	57.5
Housewife	144	54.7	9	2.7	135	52.0
Regularly employed	57	56.4	3	3.3	54	53.1
Occasionally employed	98	74.8	2	2.8	96	72.0
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed	–		–		–	
Housewife vs. occasionally employed	<.02		–		<.02	
Regularly employed vs. occasionally employed	<.05		–		<.05	

* *Unraveling Juvenile Delinquency,* Table XII-27.

TABLE IX

Work habits of father not good *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	%	*No.*	%	*No.*	%
Total	282	62.4	132	28.9	150	33.5
Housewife	139	57.0	81	25.8	58	31.2
Regularly employed	57	62.6	29	39.2	28	23.4
Occasionally employed	86	73.5	22	31.9	64	41.6
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed	–		–		–	
Housewife vs. occasionally employed	<.05		–		–	
Regularly employed vs. occasionally employed	–		–		–	

* *Unraveling Juvenile Delinquency*, Table IX-18, Categories: Fair and Poor.

in contrast with 57% of the delinquents whose mothers remained at home as housewives. It would therefore appear that a boy both of whose parents are industrial liabilities is more likely to become a delinquent than is one who is not the son of such inadequate parents.

Economic pressure on the mother to contribute to the family income was caused not only by the industrial incapacity of the father but also by his absence from the home by reason of death, desertion, separation or divorce. In Table X there is evidence that where homes were broken a higher proportion of mothers sought regular employment. This is true in the case of both the *non-delinquents* and the *delinquents*. Among the latter a significantly higher proportion of mothers were employed either regularly or occasionally. The absence of the mother in gainful employment would appear to furnish added pressures to the circumstances of an already broken home in making for delinquency in the children.

Another factor acting as an economic pressure on a mother to seek employment outside the home is the emotional illness of her spouse. The evidence that mothers work because of the need created by the emotional illness of the husband is certainly reflected in the cases in *Unraveling Juvenile Delinquency*. This is now seen in the higher proportion of such mothers of both delinquents and non-delinquents engaged in gainful employment. In the case of the *non-delinquents* it is reflected in a higher percentage of mothers working regularly, and among the *delinquents* in the significantly greater proportion of mothers working occasionally. As far as the relationship to delinquency is concerned, it is

evident that the combined circumstances of emotional disturbance in the father and the absence, especially the erratic absence, of the mother from home in gainful employment contribute to the delinquency of the children.

It is to be borne in mind that all the boys who were the subjects of *Unraveling Juvenile Delinquency* were residents of economically underprivileged areas and that by far the greater proportion of both the delinquents and their matched non-delinquents were from homes of low economic status (*i.e.,* marginal or dependent). In such circumstances a mother may have been forced to help in the support of the family or turn to welfare agencies and relatives for assistance. From Table XII we get a clear reflection of the influence of economic necessity on the working of the mother and in turn on the delinquency of the children. Here we focus on those families which were very generally dependent on outside sources of support. In the homes of the *non-delinquents* there was relatively little financial dependency. However, among the families of *delinquents* who were forced to rely on sources of support other than the earnings within the family a significantly higher proportion of the mothers were only occasionally rather than regularly employed women; and this fact appears to have had some bearing on the delinquency of the children. In other words, rearing in a home in which the income is so insufficient for the family as to necessitate supplementation by welfare agencies and other sources and in which the possible inadequacy of the mother as a wage-earner is reflected in her sporadic employment appears to have a deleterious effect on the children; for a significantly

TABLE X

Boy reared in broken home *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	%	*No.*	%	*No.*	%
Total	299	60.3	169	34.0	130	26.3
Housewife	133	50.6	102	30.6	31	20.0
Regularly employed	74	73.2	41	45.1	33	28.1
Occasionally employed	92	69.7	26	35.6	66	34.1
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed	<.02		<.10		–	
Housewife vs. occasionally employed	<.02		–		–	
Regularly employed vs. occasionally employed	–		–		–	

* *Unraveling Juvenile Delinquency,* Table XI-8.

TABLE XI

Father emotionally disturbed *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	%	*No.*	%	*No.*	%
Total	219	44.2	90	18.1	129	26.1
Housewife	100	38.0	49	14.7	51	23.3
Regularly employed	48	47.5	25	27.5	23	20.0
Occasionally employed	71	53.8	16	21.9	55	31.9
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed	–		<.10		–	
Housewife vs. occasionally employed	<.05		–		–	
Regularly employed vs. occasionally employed	–		–		–	

* *Unraveling Juvenile Delinquency*, Table IX-10.

TABLE XII

Family financially dependent *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	%	*No.*	%	*No.*	%
Total	179	36.1	73	14.7	106	21.4
Housewife	92	35.0	49	14.7	43	20.3
Regularly employed	26	25.7	13	14.3	13	11.4
Occasionally employed	61	46.2	11	15.1	50	31.1
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed	–		–		–	
Housewife vs. occasionally employed	–		–		–	
Regularly employed vs. occasionally employed	<.05		–		<.10	

* *Unraveling Juvenile Delinquency*, Table IX-14.

higher proportion of delinquents stem from such homes than from those in which the mother either works regularly or remains at home full time.

IRREGULAR MATERNAL EMPLOYMENT AS RELATED TO DELINQUENCY

Additional light is thrown on the greater inadequacy of mothers who work sporadically in the findings in Table XIII that in families of delinquent boys a higher proportion of irregularly employed mothers themselves have a history of delinquency than do mothers who were either full-time housewives or worked regularly. So here again we see reflected the special influence on the delinquency of children of some characteristics of erratically employed mothers.

We can supply one more piece of evidence about the effect on the delinquency of children of mothers who are irregular workers. In Table XIV it is shown that such women (together with their husbands) are, as a group, less self-respecting than are those mothers who engage in regular employment. This is true not only in families of delinquents but of non-delinquents as well. The significantly greater proportion of delinquents who were reared by parents who lacked self-respect and by mothers who were unstable workers as opposed to regularly employed mothers appears further to reflect a damaging effect on the children.

We already have sufficient evidence to permit of at least a guarded conclusion that the villain among working mothers is the one who seems to have some inner need to

TABLE XIII

Mother has history of delinquency *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	%	*No.*	%	*No.*	%
Total	222	44.8	75	15.1	147	29.7
Housewife	103	39.2	47	14.1	56	25.1
Regularly employed	42	41.6	14	15.4	28	26.2
Occasionally employed	77	58.3	14	19.2	63	39.1
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed	-		-		-	
Housewife vs. occasionally employed	<.02		-		-	
Regularly employed vs. occasionally employed	<.10		-		-	

* *Unraveling Juvenile Delinquency*, Table IX-10.

TABLE XIV

Parents lack self-respect *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	%	*No.*	%	*No.*	%
Total	215	43.3	48	9.9	167	33.4
Housewife	113	42.9	34	10.5	79	32.4
Regularly employed	35	34.6	4	4.4	31	30.2
Occasionally employed	67	50.8	10	14.1	57	36.7
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed	-		-		-	
Housewife vs. occasionally employed	-		-		-	
Regularly employed vs. occasionally employed	<.10		<.05		-	

* *Unraveling Juvenile Delinquency*, Table X-4.

TABLE XV

Mother dominates family affairs *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	%	*No.*	%	*No.*	%
Total	237	49.9	242	50.0	—5	—0.1
Housewife	107	42.5	150	46.2	—43	—3.7
Regularly employed	57	59.4	52	59.8	5	—0.4
Occasionally employed	73	57.5	40	55.6	33	1.9
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed	<.05		-		-	
Housewife vs. occasionally employed	<.05		-		-	
Regularly employed vs. occasionally employed	-		-		-	

* *Unraveling Juvenile Delinquency*, Table X-8.

flit erratically from job to job—probably because she finds relief thereby from the burden of homemaking and the rearing of children. But more of this may come to light as we proceed with an analysis of the evidence in our data of the effect on family life of the mother's working.

UNWHOLESOME INFLUENCE OF MATERNAL EMPLOYMENT ON FAMILY LIFE AS RELATED TO DELINQUENCY

We have thus far directed attention to the effect on the delinquency of the children of the mother's working outside the home and also to suggestions provided by our data as to the reasons why mothers of low-income levels work.

Now we turn to a consideration of the effects of the absence of the mother from home in gainful employment on the pattern of the family life. It was shown in *Unraveling Juvenile Delinquency* how crucially important a role the breakdown of the family matrix plays in the genesis of juvenile delinquency. The question now is to what extent a mother's working contributes to this breakdown.

There are four tables in our series that shed some light on this. Incomplete as the data are they are nevertheless suggestive, for they treat of domination of the home by the mother, the effect on the father's relationship to the children when the mother is out working, the effect on the relationship between the mother and father, and finally the effect on the cohesiveness of the family group.

As all these factors except domination of the household by the mother were found in *Un-*

TABLE XVI

Father's discipline of boy is not consistently firm and kindly *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	%	*No.*	%	*No.*	%
Total	429	94.4	202	44.3	227	50.1
Housewife	238	94.4	120	38.2	118	56.2
Regularly employed	77	90.6	42	54.6	35	36.0
Occasionally employed	114	96.6	40	61.6	74	35.0
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed	–		<.05		<.05	
Housewife vs. occasionally employed	–		<.05		<.05	
Regularly employed vs. ocassionally employed	–		–		–	

* *Unraveling Juvenile Delinquency*, Table XI-22, Categories: Lax, Overstrict and Erratic.

TABLE XVII

Parents are incompatible *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	%	*No.*	%	*No.*	%
Total	310	63.2	170	34.6	140	28.6
Housewife	138	52.5	93	28.3	45	24.2
Regularly employed	77	76.2	43	47.3	34	28.9
Occasionally employed	95	75.4	34	47.2	61	28.2
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed	<.02		<.05		–	
Housewife vs. ocassionally employed	<.02		<.05		–	
Regularly employed vs. occasionally employed	–		–		–	

* *Unraveling Juvenile Delinquency*, Table X-7, Categories: Fair and Poor.

raveling Juvenile Delinquency to be related to delinquency, whatever special bearing the employment of mothers may have on these particular aspects of family life may in turn be regarded as contributing additionally to the delinquency of the children.

First, as regards domination of the household by the mother (frequent in the modern American family), there is some inkling even in the homes of the *non-delinquents* that a higher proportion of employed mothers play the guiding role in the household affairs than do mothers who are not gainfully employed. This is more clearly evident in the homes of the *delinquents* where a greater percentage of both the regularly employed and sporadic workers than of full-time housewives dominated the family affairs. However, since the total incidence of this influence is quite similar among delinquents and non-delinquents, it cannot be said that this is a factor contributing to delinquency of the children.

It is clearly evident from the findings among the *non-delinquents* in Table XVI that lax, erratic or overstrict discipline of the children on the part of the father was far more prevalent among the families in which the wife went out to work either regularly or occasionally than in those in which the wife devoted all her time to domestic duties. Whether, in the absence of the wife, the husband usually tends to be more neglectful of the children or less patient with them or whether the wife seeks escape from the home because of the vagaries of her spouse is a moot question. At any rate, to the extent that a mother's absence from home in gainful employment engenders a father's inadequate discipline of the children the working mother must be charged with contributing, albeit indirectly,

to the delinquency of her children. Poor discipline of the children by the father is evidently a very potent factor in delinquency as it occurred in 90% to 97% of all the delinquents regardless of whether or not the mother worked.

Whether or not the dissatisfaction of the father is visited upon the children because the mother is a breadwinner, it is evident from Table XVII that the relationship existing between him and his working spouse was a deteriorating one, in some instances already reaching open breach. This holds true of the parents of the non-delinquents as well as of the delinquents.

As the incompatibility of parents was found in *Unraveling Juvenile Delinquency* to be associated with delinquency, it can be concluded that to the extent, in turn, that a mother's working outside the home contributes to the unstable relationship between herself and her husband she contributes to the delinquency of her children. We must bear in mind, however, that in some instances she may be in gainful employment outside the home because of the inadequacy or inability of her spouse to fulfill his share of the obligations to his family.

Viewing the family situation as a whole in terms of the unity or cohesiveness of the family life ("all for one, one for all"), we see evidence in Table XVIII that more of the homes of working mothers than of housewives lack cohesiveness. This lack of family unity was found in *Unraveling Juvenile Delinquency* to be highly associated with the delinquency of children.

So, again, to the extent that the absence of the mother from home in gainful employment contributes to a weakening of the family ties, the working mother can be

TABLE XVIII

Family is not a cohesive unit *

	DELINQUENTS		NON-DELINQUENTS		DIFFERENCE	
	No.	%	*No.*	%	*No.*	%
Total	415	83.8	189	38.1	226	45.7
Housewife	207	78.7	111	33.4	96	45.3
Regularly employed	91	90.1	40	44.0	51	46.1
Occasionally employed	117	89.3	38	52.1	79	37.2
SIGNIFICANCE OF DIFFERENCES						
Housewife vs. regularly employed	<.05		–		–	
Housewife vs. occasionally employed	<.05		<.05		–	
Regularly employed vs. occasionally employed	–		–		–	

* *Unraveling Juvenile Delinquency*, Table X-14, Categories: Some and None.

charged with contributing to the delinquency of her children.

DISCUSSION

The deleterious influence on the family life and on the children of the mother's working outside the home has become evident in our analysis. As regards the special impact on delinquency this too has emerged. There is evidence of a differential influence of the working mother on family life, on children and on delinquency. There is some suggestion in our data that these influences are more potent when deriving from the mother who works sporadically than from the regularly employed mother. Actually a like proportion of mothers of both delinquents and non-delinquents were found in *Unraveling Juvenile Delinquency* to be regularly employed, but among the delinquents there was found a higher proportion of mothers who worked only irregularly. So even in *Unraveling Juvenile Delinquency* we could note that it is the working mother of this latter type who exerts the heaviest influence on the delinquency of her children.

There is some suggestion that such mothers are of a different "breed" from women who are regularly employed. It may be that the sporadically working mother is motivated more by the enticement of getting away from household drudgery and parental responsibility than is the mother who works regularly. The latter is seemingly more interested in the need or duty of providing a steady addition to the family income.

As is true of all studies of this kind, the findings must be considered tentative. The traits and factors included in this analysis are only a sample of many other influences that may be operative. More detailed studies of the relationship of the working mother to delinquency and to family and social malaise are needed.

That wholesome family life is of crucial importance in the building of character, the inculcation of basic habits, the development of a sense of security and the structuring of personality has been so frequently asserted in clinical case histories, statistical studies and theoretical speculation as to have become a commonplace. There is, of course, some difference of opinion as to what "wholesome" means. Does it, for example, have to do largely with affectional relationships of parents (especially the mother) to children, with problems of overprotection, with methods of discipline, with the effect of parental rejection or parental neuroticism, alcoholism or criminalism, and their influence on the growing child, or with some or all of these? At all events, the central significance of the family matrix for the destiny of the child, even apart from the problem of delinquency, can nowadays no longer be denied.

From a practical point of view the issue presented by our findings is not a simple one. It may be generalized that women seek employment outside the home for economic reasons. However, in many instances there are doubtless more deep-lying and subtle motivations. In some cases we are confronted with mothers who for intellectual or temperamental reasons cannot or will not adequately fulfill the role of motherhood. This would seem to suggest the need of individualization in determining how to improve the situation in the homes of working mothers. An overall governmental policy of financial grants to mothers is not enough and may even be disadvantageous in some cases where it is not true economic need but rather the desire for the latest gadgets to "keep up with the Jones's" that may be the propulsive motive. Thus not only economic help but educational,

psychiatric and spiritual aid as well must be called into play in the constructive management of this growing social problem.

We have limited ourselves to very general suggestions. Our task essentially is to present findings growing out of the research which was the basis of the volume *Unraveling Juvenile Delinquency*. No doubt those who are directly concerned with seeking programmatic and legislative remedies to cope with such dangers as this all-too-inadequate study has pointed to will clothe our bare outline with many practical suggestions. For example, if the greatest danger to children derives from the mother who is a sporadic worker, such a mother appears to be in need of special counseling and her family of special attention.

There are a few more facts that we can add from the research reported on in our latest volume, *Physique and Delinquency*.[19] In this we made a breakdown by body type of the 500 delinquents and 500 non-delinquents encompassed in *Unraveling Juvenile Delinquency* (mesomorphs, endomorphs, ectomorphs and the balanced type); and this disclosed that so far as the problem of working mothers is concerned we need be most seriously concerned about *ectomorphic* children. Youngsters of this body type are predominantly linear, fragile and sensitive. In proportion to their mass they have the greatest surface area and hence, according to Sheldon, "the greatest sensory exposure to the outside world." [20] Employment of the mother outside the home was found to have its most potent delinquency-inducing effect on ectomorphic youngsters, in contrast with those of the other body types.[21] So, also, ectomorphs tend to react more markedly than one or more of the other physique types to such unfortunate circumstances in their environment as unsuitable supervision by the mother, maternal hostility or indifference to the child, emotional disturbance of the father, broken homes, inconsistent, overstrict or lax discipline from the father, incompatibility between parents, lack of family cohesiveness and rearing by a parent substitute.[22]

In all these respects, then, whatever damage to the personality and character of children may result from the fact of the mother's absenting herself from the home in gainful employment is enhanced in the case of the particularly vulnerable ectomorphic child. For we have learned in *Physique and Delinquency* that children of this body build are more sensitive and less stable emotionally than are boys of other body builds.[23]

Here again the evidence suggests that a mere mass program of financial subsidy to induce necessitous mothers to remain at home is not enough. Individualization is called for, both of the child and the family; and financial aid must be supplemented by assistance in the form of educational, religious and psychotherapeutic guidance.

Basically, the time is ripe for a reassessment of the entire situation. As more and more enticements in the way of financial gain, excitement and independence from the husband are offered married women to lure them from their domestic duties, the problem is becoming more widespread and acute. It is a problem that should be discussed freely and frankly in all communities by mothers, fathers, clergy, psychiatrists, social workers. Only through the ventilation of the pros and cons of the problem, supported by such facts as exist, can a most vital issue of modern life be dealt with fairly and constructively.

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[19] New York, Harper & Brothers, 1956.

[20] See W. Sheldon, *et al.*, *The Varieties of Human Physique*, New York, Harper & Brothers, 1948, 5–7.

[21] *Physique and Delinquency, op. cit.*, 174–75.

[22] *Ibid.*, 167, 180, 181, 189, 193, 196, 197, 201, 203.

[23] *Ibid.*, 236, Exhibit 10.

APPENDIX A-1

Factors in unraveling juvenile delinquency significantly differentiating delinquents from non-delinquents and to which mother's working is not found to bear a significant relationship *

(Table number to right of each factor is from *Unraveling Juvenile Delinquency*)

PHYSICAL FINDINGS

Extreme restlessness in early childhood (XIV-2a)
Enuresis in early childhood (XIV-2b)
Dermographia (XIV-13a)

QUALITIES OF INTELLIGENCE

Power of observation (XVII-4)
Common sense (XVII-6)
Tendency to phantasy (XVII-8)
Methodical approach to problems (XVII-10)

BASIC CHARACTER STRUCTURE

Social assertion (XVIII-2)
Defiance (XVIII-3)
Submissiveness to authority (XVIII-4)
Ambivalence to authority (XVIII-5)
Enhanced feeling of insecurity/anxiety (XVIII-7)
Feeling of not being wanted or loved (XVIII-8)
Feeling of not being taken seriously (XVIII-10)
Feeling of not being recognized or appreciated (XVIII-11)
Feeling of helplessness or powerlessness (XVIII-12)
Fear of failure and defeat (XVIII-13)
Feeling of resentment (XVIII-14)
Surface contact with others (XVIII-17)
Suspiciousness (XVIII-23)
Destructiveness (XVIII-24)
Feeling of isolation (XVIII-25)
Dependence on others (XVIII-27)
Conventionality in ideas, feelings, behavior (XVIII-29)
Feeling of being able to manage own life (XVIII-32)
Narcissistic trends (XVIII-33)
Masochistic trends (XVIII-34)
Receptive (oral) trends XVIII-35)
Destructive-sadistic trends (XVIII-36)
Emotional lability (XVIII-37)
Self-control (XVIII-38)
Vivacity (XVIII-39)
Compulsory trends (XVIII-40)
Extroversive trends (XVIII-41)
Psychopathy (XVIII-43c)

TRAITS OF TEMPERAMENT

Suggestibility (XIX-1b)
Inadequacy (XIX-1c)
Stubbornness (XIX-1d)
Adventurousness (XIX-1e)
Motor response to stimuli (XIX-1f)
Emotional stability (XIX-1g)
Acquisitiveness (XIX-2c)
Conventionality (XIX-3a)
Conscientiousness (XIX-3c)
Practicality (XIX-3d)

FAMILY BACKGROUND AND ATMOSPHERE

Cleanliness and neatness of home (VIII-8)
Father alcoholic (IX-10b)
Father serious physical ailment (IX-10d)
Mother alcoholic (IX-10b)
Mother emotionally disturbed (IX-10g)
Family's management of income (X-1)
Routine of household (X-2)
Ambitiousness of family (X-5)
Family group recreations (X-11)
Attitude of parents regarding entertaining children's friends at home (X-12)

* This does not necessarily mean that a relationship definitely does not exist, but only that it is not revealed in our data.

Provisions for recreation in home (X-13)
Affection of father for boy (XI-13)
Affection of mother for boy (XI-14)
Emotional ties of boy to father (XI-15)
Emotional ties of boy to mother (XI-17)
Boy's estimate of mother's concern for his welfare (XI-19d)
Mother's discipline of boy (XI-22b)
Method of control of boy by father (XI-23c)
Method of control of boy by mother (XI-23d)

SCHOOL HISTORY

Retardation (XII-5)
Scholarship (XII-10)
Reading quotient (XII-11)
Attitude toward school (XII-17)
Academic ambitions (XII-19)
Adjustment to schoolmates (XII-21)
Truancy (XII-26)

USE OF LEISURE AND HABITS

Household duties (XIII-10)
Recreational preferences (XIII-11)
Stealing rides (XIII-13a)
Keeping late hours (XIII-13b)
Smoking at early age (XIII-13c)
Sneaking admissions (XIII-13d)
Destroying property (XIII-13e)
Running away from home (XIII-13f)
Bunking out (XIII-13g)
Gambling (XIII-13h)
Drinking at early age XIII-13i)
Hanging around street corners (XIII-14a)
Seeking recreation in distant neighborhoods (XIII-14b)
Using playground (XIII-14d)
Companionships (XIII-16a)
Attitude toward supervised recreation (XIII-20)
Church attendance (XIII-21)

APPENDIX A-2

Factors in unraveling juvenile delinquency not differentiating delinquents from non-delinquents and to which mother's working is not found to bear a significant relationship *

PHYSICAL FINDINGS

Irregular reflexes (XIV-6a)
Functional deviations (XIV-6b)
Sexual underdevelopment (XIV-9a)
Cyanosis (XIV-13b)
Tremors (XIV-13c)
General health (XIV-16)

QUALITIES OF INTELLIGENCE

Intuition (XVII-7)

BASIC CHARACTER STRUCTURE

Feeling of not being taken care of (XVIII-9)

TRAITS OF TEMPERAMENT

Preponderance of introversive trends (XVIII-42)
Sensitivity (XIX-1a)

FAMILY BACKGROUND

Nativity of parents (IX-2)

* See note to A-1.

HARRY LEVINSON, PH.D.

Social action for mental health

Social action for mental health, whether on a national, state or local level, may be divided into five phases: explanation, investigation, mobilization, legislation and sustentation.

EXPLANATION

A problem to be solved must first be recognized. When the problem is to be solved by collective action, then it must be recognized by those who must act. Thus the first step in social action for mental health is to call attention to situations which must be remedied—through newspapers, magazines, radio, television, pamphlets, speeches and other methods of communication. Explanation may originate from the communications medium itself, as in newspaper exposés of state hospital conditions, or it may originate from the mental health association.

In Kansas, as in many other states, both approaches were used at different times for different purposes. The conditions which gave rise to the initial reforms of the Kansas state hospital system made exciting copy for newspapers. As a result at least four different newspapers spontaneously undertook exposés. These were supplemented by pamphlets which highlighted the proposed changes.

Many publications over the country have undertaken similar exposés. Most familiar is the work of the Baltimore *Sun*, the *Life*

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exposé of 1946 and the writings of Albert Deutsch, Albert Q. Maisel, Mrs. Edith Stern and others.

Once the initial echoes of scandal have subsided, however, newspaper headlines tend to diminish in size. The slow progress of actual change has neither the emotional impact nor the glamour of the scandal. When public interest must be attracted to less exciting but nonetheless important issues, the mental health association or other citizens' groups must often themselves prepare materials for communications media.

Four years after the initial surge of reform in Kansas it was necessary to seek passage of a constitutional amendment by referendum to permit a permanent tax levy for state hospital buildings. Without the attraction of "hot" news and having given considerable attention to the state hospitals four years before, newspapers had little incentive to send their own correspondents to the hospitals for comprehensive stories.

Under the sponsorship of the Kansas Association for Mental Health a series of five stories for newspapers was prepared, one on each of the state mental institutions. Each was accompanied by a mat with which the newspaper could easily and inexpensively illustrate the conditions described. From an accompanying fact sheet, information for editorials was made available. The cost to the newspapers was practically nothing, yet each could have the satisfaction of helping push an important state reform.

Almost every daily and many weeklies in the state used the stories. This series too was supplemented by a small pamphlet, *Stairs to What?* distributed widely over the state. Total cost for preparing and distributing the articles and 250,000 pamphlets was less than $1,200, a sum returned by the sale of pamphlets to interested organizations which distributed them.

To be effective, association-originated explanation should be prepared only by persons who know something about journalism. Many such volunteers are available. Newspaper editors haven't time to doctor the compound verbal fractures of the uninitiated nor will the average citizen attempt to decipher a mass of type or to digest contents of a sheaf of mimeographed papers. The object of explanation, after all, is to brief the citizen, not to bore him.

The explanation, whether medium-originated or association-originated, to be successful as a method of preparing for social action must encompass certain specifics: (a) it must *detail* the conditions which require change, (b) it must *contrast* these conditions with what they should and could be, (c) it must *explain* and interpret the "why" of proposed change, especially in the field of mental health where the "why" is not often readily apparent to the layman, and (d) it must be *timed* so as to immediately precede the opportunity for action.

More than one effort to improve mental hospitals has failed dismally because no one indicated specific remedies for the problems uncovered. Missouri, for example, built excellent occupational therapy facilities in its state hospitals to meet an accepted need. However, it has no staff to make effective use of them. While the need was apparent, the method of meeting it was ineffectual. Kansas was particularly fortunate in that the specific recommendations presented to its citizens called for the establishment of a training program at the Topeka State Hospital and the employment of enumerated personnel. Kansans were repeatedly told that buildings alone could not get patients well. This made it impossible to obscure the problem with a facade of new buildings.

The fortunate timing of the Kansas exposés in the fall of 1948 made the issue a live one for the 1949 legislature. Had they been printed six months earlier their im-

pact would have been considerably dissipated by the time the legislature convened.

INVESTIGATION

Successful explanation usually is followed by legislative or executive investigation or both. Those who create laws and those who must administer them require detailed, official and authoritative information upon which to predicate change. They cannot depend entirely upon explanation directed to the public at large, although if explanation is soundly conceived and logically concluded it may well become an important part of the investigation report.

Investigation has several values. Usually investigation removes the problem from the realm of special interest and gives it official recognition as a problem of government. The report of the investigation becomes an official public document upon which action is to be based. The 1953 report of the Kansas legislative council, for instance, contained an excellent example of a detailed blueprint for legislative action concerning mental hospitals. The report, incidentally, also became another means of calling public attention to the problem and a concrete point around which to rally public support.

Investigative bodies as a rule consult recognized experts in mental health, frequently representatives of national professional organizations. These persons lend weight, authority and prestige to the attack on the given problem as well as indicate recommendations derived from a consensus of their members. Authorities from outside the community bring to investigation the distilled experiences of other communities or states. Taken together, these contributions of the expert add immeasurable impetus to the movement toward social action for mental health.

The work and report of the investigation are news. Newspapers not only report this news but they also often comment upon it editorially. Thus explanation is restated and amplified.

At this point the mental health association acts most effectively by standing by. This permits those who conduct the investigation to call upon the association for help as needed. More important, it permits public attention to be focused exclusively on the investigation.

MOBILIZATION

The process of assembling, organizing and guiding large numbers of citizens toward a social goal is probably the most complex phase of social action. The details involved are myriad.

Having clearly defined a social goal in the process of explanation and investigation, the mental health association next enlists the support of other citizen groups. In Kansas this was done by personal contact with presidents or legislative chairmen of state-wide organizations wherever possible. When personal contact was not possible, letters were written which clearly described the action to be taken and the proposed role of the organization whose help was being sought: *e.g.*, endorsement of the proposals, dissemination of information to members, *etc.* Many small groups which were unaffiliated were reached by letter after they had contributed clothes, games and other items to the state hospitals.

As the front of attack broadens, organizations are included which are less familiar with mental health problems than the mental health association is. It becomes increasingly important therefore that the essentials of proposed change be stressed again and again, together with the important arguments which support them. People have to know what it is they are trying to

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change and why. Their knowledge cannot be taken for granted.

Mobilization is the build-up, the tension-building period. It is at this point that all available media of communication must be focused on the problem. Reports of new support, endorsement of added organizations, the comments of prominent individuals—all merit publicity. Radio broadcasts, television interviews or features, and speakers are most effective during this period. Eye-catching but simple broadsides should be widely distributed.

Contacts with newspapers and newspaper men which were established in the explanation phase should be carefully maintained. Not only does the association thus keep the newspapers informed about the progress of its action but also the newspaper men frequently are able to apprise the association of the degree to which its efforts are meeting with public interest and acceptance. In addition, these contacts will become even more important as the effort moves forward for reasons which will be outlined below.

The mobilization phase is also the period in which public opinion is crystalized. It is from this crystalization that legislators learn what their constituents want. Candidates campaigning for legislative office are asked by voters what they will do about the problems posed. Those who are already in office may well be visited by delegations of their constituents who will explain their personal interest in the action taken.

As mobilization begins to crystalize, various political figures will identify with the movement. Others will be willing to identify themselves with the proposed action *if* they are encouraged and invited to do so. The association is thus able to cooperate with key legislators who will be interested in remedying conditions. It is extremely important to the potential success of the project that political considerations be kept in mind in these relationships.

The raw facts of political life are that social action on a legislative level will have greater chance for success if: (a) it is supported by the administration in power, (b) it is sponsored by the dominant faction in the legislative body, (c) it is supported also by respected leaders in the minority faction, and (d) prior agreement can be reached to remove the issue from partisan considerations.

Political executives or those campaigning for executive offices should be consulted early in the process of mobilization, not only for the purpose of informing them but also because such consultation will enable the association to assess the degree of interest and sophistication of leadership or potential leadership. It must be remembered further that legislative calendars, committee action and appropriations are usually controlled by the administration. Informed leaders or potential leaders often will, in public statements, commit themselves in advance to the action to be taken. Ignored leadership can only impede action.

Any proposal for action will require introduction into the legislative body, assignment to committees, guidance through the committees and through debate on the floor, and approval of the body and executive. It is important therefore that proposals be sponsored by legislators of both the majority and minority parties who are known and respected for their judgment and conservatism.

To be able to actively push proposed legislation, the legislative sponsors must be thoroughly briefed. They must be familiarized with the conditions to be changed and the reasons for change, with the facts and figures which demonstrate the need for change, and with the nature and degree of possible opposition. Considerable time and

effort may be saved if bills embodying the proposed action are prepared in advance of the legislative session so that those who will be responsible for them can become thoroughly acquainted with their provisions and thereby be better able to guide them through legislative channels.

In the 1952 Kansas referendum the endorsement of both major party candidates for governor removed the issue from partisan consideration and eliminated possible partisan opposition. Written endorsements were obtained by the association from both candidates and were publicized widely both in the press and in the pamphlet *Stairs to What?*

On the other hand, at about the same time, when sweeping recommendations for reforms in state hospitals in Missouri were made by a committee of the Republican-dominated house of representatives, the Democratic-dominated senate rejected them. So bitter did the fight become that the senate recessed without passing appropriations bills. Much acrimonious criticism flared back and forth between the two houses, and finally a Democratic governor vetoed most of the proposed advances. Progress toward improved mental hospitals in Missouri probably was set back ten years. Social action for mental health in Missouri will be tinged with partisan flavor and heat for some time to come.

LEGISLATION

The first few weeks after legislative bodies convene are devoted to internal organization. This period is something of a vacuum for legislators and is usually the only time during the session when they have time to spare. In Kansas, particular advantage was taken of this opportunity.

Individual organizations in local communities which had shown interest in the Topeka State Hospital by gifts or services were invited to send small delegations of about five persons each to the hospital. These people were taken on an extensive tour of the hospital during which specific attention was given to those matters on which legislative action was to be requested. Each group then visited its respective legislators and the governor to tell them what they had seen and of their interest in the improvement to be made. In addition, the activity of each group was reported in its hometown newspaper. The importance of this first-hand grass-roots report can hardly be over-estimated.

A variety of groups was represented. One was a Knights of Columbus lodge, another a mental health association chapter, another a committee from a ministerial association, another a women's club, and so on. The range of groups indicated that their vested interest was that of citizens broadly and not one particular segment of the population.

Although most legislatures have only two legally constituted bodies, it is often said that there are actually four "houses": representatives, senators, wives of legislators, and lobbyists. In Kansas at least, wives of legislators form themselves into a social club for the duration of the legislative session. The volunteers at Topeka State Hospital offered their hospitality to the legislative wives and divided their guests into small groups. Each group was taken on a tour of various parts of the hospital during which the volunteers described their work, the progress of the hospital and the handicaps under which the hospital functioned. After the tour the volunteers presented entertainment and refreshments. No official of the institution even so much as made a welcoming speech or was present in any way. It was strictly the volunteers' show.

Two years later the same project was undertaken with equal success. By that

time the legislative wives had come to expect such an invitation, so the invitation is renewed every two years. Improvements which have been made in the institution between visits are conspicuous to the visitors who in turn tell their husbands about them. Thus interest in the progress of this institution, on the part of this group at least, is sustained and continuous.

Following the visit of the wives, the next step was to invite the legislators themselves to the hospital. Every day during several legislative sessions the writer went to the legislature and invited four or five legislators to tour the institution. Each group spent a minimum of two hours on tour after which the visitors were given an opportunity to ask questions of the superintendent. Personal observation of and contact with the institution inevitably led to a feeling of personal responsibility on the part of the legislators, and also to a feeling of pride for achievements accomplished.

Legislative committee chairmen were invited to send their entire committees to the hospital, instead of the usual 2-man subcommittees. This move was extremely important for the actual work of legislation is done in committees. Seldom is there time for detailed examination of proposals on the legislative floor. The formal recommendations of committees are most often accepted in substance by the legislative body, especially when they are free of partisan considerations. What goes on in committees determines the outcome of legislative proposals.

When legislators visited, newspapermen were informed so that stories of the visits and comments of the legislators could be published in hometown newspapers. Many legislators wrote newspaper columns for their home communities into which they incorporated the news of the visit and their observations about the needs to be met.

About the time that consideration was being given by committees to bills relating to the hospital, illustrated pamphlets were distributed to the legislators and to civic groups over the state. Members of the civic groups were reminded that this was the opportune time to write legislators about their interest in mental health advances. Newspapers, supplied with fresh material, were encouraged to publish additional explanation.

A special word must be said about the pamphlets which were used in three legislative sessions. The three pamphlets were *A Study in Neglect* * produced in 1949 by the Kansas State Board of Health, *Behind These Walls* * published in 1951 by the Shawnee County Association for Mental Health, Topeka, and *Doors Are to Open* presented in 1953 by Topeka State Hospital. Although because of lack of funds the latter two left much to be desired from the printing point of view, the construction of each was guided by the same principles. First, neither the titles nor the covers gave away what was inside. Rather, they tended to arouse curiosity and cause the pamphlet to be opened. This often saved the publications from immediate filing in the wastebasket along with dozens of other pamphlets, books and other miscellany a legislator gets each day. Second, the latter two pamphlets contained primarily illustrations with a minimum of copy. The legislator, and anyone else for that matter, could literally *see* the argument. Copy was abrupt and emphatic to the point of sharpness. Lastly, each presented the cogent issues to be acted upon in definitive summary form coupled with a perspective on the progress which had been made. Cost of *Behind These Walls* was about $500 for 2,000 copies and for *Doors Are to Open* about $400. I

* Out of print.

have personally observed that even when the legislative session was over and legislators were dumping drawers of materials these pamphlets were often set aside to be used for future reference.

For purposes of committee action, mental health associations need to be prepared to present expert witnesses, repeat information about needs and supply additional statistics. Rigid self-censorship is necessary, however, for committees have neither the time nor the patience for involved explanations or complex reasoning.

Direct constant daily contact with legislatures is imperative. From friendly legislators, lobbyists and newspaper men comes a constant flow of information on the day-to-day progress of the action. Newspaper men, especially, hear all kinds of things from all kinds of sources. It is at this point that the previously established relationships with newsmen yield rich rewards. It was from a newspaper man, for instance, that we learned an economy organization was going to exert pressure on the legislature not to implement the building fund referendum. Before the opposition completed distribution of its letters to the legislators the mental health association was attacking the argument in the public press. The opposition was defeated almost before it began!

Such information, plus the careful scanning of bills as they are introduced, amended and passed on, permits the association to discover and deal with sources of opposition, to detect and strengthen weak links in its organization, to marshal new evidence if the old is inadequate and to catalyze its components into letter-writing, visits or other action if progress lags. Such steps require rapid dissemination of up-to-date developments to the components concerned.

Several considerations must be kept in mind in working with legislators: (a) high pressure produces resentment and resistance, (b) factional fights must be carefully avoided, and (c) timing is the tight rope of all legislative efforts.

The first consideration is often forgotten at high cost. Most legislators are more concerned with their self-respect and feeling of achievement than they are with whether they will be re-elected. At least this is true in the writer's experience. If a legislator is not in favor of a given mental health measure, this usually means that he has not been adequately informed or convinced. Increased efforts to inform and convince will pay far more long-range dividends than bullying.

In any legislative body there are factional fights. Careful attention to all of the various factions will prevent the mental health measures from becoming the baby of any one of them and thereby the subject of attack or revenge.

Timing must be constantly in the forefront of all legislative planning.

SUSTENTATION

The mental health association's responsibility does not end with the achievement of a given goal. It must now see that the action taken is implemented, that changing conditions or practices are met and that the achievement is not destroyed by subsequent counter-action. All too often, once a social goal has been achieved, the group which sponsored the change rests on its laurels. This can have unfortunate results.

Some months after the 1951 Kansas legislature adjourned, certain radical administrative changes were made in one of the Kansas institutions in keeping with the intent of the legislature and the recommendations of those concerned with mental health. These changes, however, immediately produced negative reactions in the community

in which the institution was located. The state administration was sharply attacked for the steps it had taken.

At a time when state officials needed the support of those who had sought the changes, the initiating organization was demobilized. The administration had to fight its battles alone. Fortunately the caliber of state officials was such that they did not thereafter avoid constructive efforts for mental health. But such an experience might well have resulted in a reluctance to undertake further progressive changes. A program of continuous support will avoid such dangers.

This means that there must be continuous explanation and interpretation, a steady flow of information about new services available to the public, how such services may be used or are being used, and periodic reports of the effects of the action. Business has learned that when you stop advertising sales go down. That axiom indeed applies to social action for mental health.

ALEXANDER SZATMARI, M.D.

Special mental health problems of refugees

The dramatic revolutionary events in Hungary and the subsequent mass flight from the country towards the West are raising serious problems—not only in economic and sociological areas—but also in the area of mental health.

It is well known that some newly-landed immigrants show unhealthy emotional reactions—anxiety, hostility, suspicion, paranoid attitudes—even when their entry was preceded by a long stay outside their native country in refugee camps, as was seen after World War II.

The current Hungarian immigration is very different and sharply challenges all those who are working with the refugees. We must consider important factors in their experience which might be responsible for emotional upsets. Among these is the fact that they are mostly young men who were born, raised and educated in a totalitarian society which is characterized by the so-called irrational authority. Under this kind of authority, interpersonal relationships and the human personality are forcefully adjusted to their social role. They in turn conform to the ever-present authority in order to survive. As Erich Fromm states, "In order that a society should function well, the members of that particular society must acquire the kind of character which makes them want to act the way they have to act. They have to desire what objectively is necessary for them to do. The outer force has to be replaced by inner compulsion."

The totalitarian society with its irrational authority attempts to break the will, the

Dr. Szatmari, a neurologist and psychiatrist of Toronto, formerly of Budapest, prepared his comments for the Canadian Mental Health Association.

spontaneity and the independence of its citizens but as man is not born to be broken there is initiated a fight for freedom—for freedom to be himself, a human being, and not an automaton. What we see in individuals can occur in the whole society and that is what certainly must have happened in Hungary. Otherwise it would be rather difficult to understand how people who had more or less good positions were the first to revolt against authoritarianism—scientists, artists, university students.

The sudden flight into Austria brought the countries of the West into a very difficult position. They had to make a vast redistribution of people partly because of the threat to Austria's economy and partly because of the unstable political situation.

After World War II people who left their country lived for a couple of years in camps and had some time for acclimatization to a new situation—to think over what they wanted, where they would like to go and what type of work they would be able to do. The Hungarian immigrants, on the other hand, have not been in a position to acclimatize themselves to the changed situation or to understand democratic principles. They do not know really what they can expect from a democratic free country and they do not know what they are expected to give to the country. Suddenly they feel totally free—free from persecution, free from death—but they are yet unable to realize to the full extent what it means, especially in the matter of responsibilities. Some of them feel that being in a "free country" means they can do whatever they want. This of course, can create resentment in those people who are working with them.

The shift from the irrational to the rational authority is therefore fraught with difficulties. There has to be education and adaptation; and if the new circumstances of life are not fully explained and illustrated, the changeover cannot be smooth, creating insecurity and consequent anxiety. When they left their country some of them were fighting; all of them were received in Austria as well as in their new country as heroes. It is very difficult to explain to a man who was living in an authoritarian society that the the time for being a hero is finished, that he now has to be just a simple, small member of a society.

Another important factor leading to the problems created by anxiety is the different concept existing in European countries about social security. In those countries the feeling exists that the state—even a non-Communist state—is responsible for the individual's well-being. Even when this well-being represents a low level of life the presence of state responsibility decreases anxiety and concern about one's future. This is not so true in North America, where society is based on the principle that a man must achieve his own social security by his individual initiative, capacities, decisions and application—with very limited protection from vicissitudes over which he has no personal control. Here again adjustment is difficult because the change is so rapid.

To summarize these difficulties, I think the following points should be considered as possible sources of insecurity and anxiety:

- The time factor for acclimatization.
- The difficulty in shifting from irrational to rational authority.
- Reintegration of values.
- The evaluation of one's social role.

EDITH M. STERN

She breaks through invisible walls

With a portable victrola and a touch of the hand a dancer named Marian Chace has started thousands of mental patients on the road to recovery. Going along with her day after day as she did her healing work at St. Elizabeths Hospital, Washington, D. C., I saw seeming miracles occur. Women, rigid and remote in catatonic stupor, began to move again and even faintly to smile. Angry manics, shouting imprecations and obscenities at their "voices," their attendants and their fellow-patients when we came in, quieted down within a very few minutes, stopped their restless pacing and sudden aimless darting across the floor and joined in group relaxing exercises. Zombie-like men, who for years had failed to respond to all other forms of treatment and were sunk deep in silence and apathy, one by one rose from the benches on which they were listlessly sitting or lying and came alive, tossing a ball to music, talking and rhythmically swinging their arms and legs.

Marian Chace's way with mental patients, like that of anyone successful in helping them, is partly an intangible matter of personality. Radiant and relaxed, gracious and mature, she emanates sensitivity and understanding. But fortunately the crux of her spectacular ability to reach the unreachable, to win over the hostile, to strike the spark of life again in the living dead, to reassure those so hurt and frightened by reality that they dare not let themselves move or speak, is both specific and imitable. To break through the invisible walls with which all psychotics surround themselves to keep people away, she uses primitive means of communication that go deeper than

Mrs. Stern is well known for her popular magazine articles and books on aspects of mental illness and health. A new edition of her widely-read *Mental Illness—A Guide for the Family*, originally published in 1942, appears on Harper & Brothers' current list.

words—rhythm, movement and touch. Old and fundamental as humanity itself, simple and universal as mothers' crooning and rocking their babies in their arms, these catch patients off guard, painlessly crumble their defenses, make them more receptive to other approaches. Over and over again she demonstrates that there is more strength in the mentally ill than most of us realize, and that they can use it if we do not frighten them.

I went with Marian Chace to a locked ward of disturbed women, most of them just admitted. "I have no idea what we'll run into," she told me beforehand. "So you'd better leave your eyeglasses and earrings in my office. These patients are about as sick as anyone can get; they're quarrelsome and assaultive, and their movements are quick and unpredictable."

But I didn't have a bit of trouble during the hour and a half I sat beside the victrola. Let a woman approach me lowerингly or suspiciously, all I had to do was to smile and say, "I'm a friend of Miss Chace's," and she would drift quietly away. Via a few old-timers on the ward, and the hospital grapevine, Miss Chace explained to me later, word had got round that she was a "safe" person who didn't intrude, didn't demand anything of you. "I simply create an atmosphere in which they are free to dance—if and as they wish," she says.

Nothing could have been less like the usual dancing class than the session of dance therapy. There was no attempt to teach steps or skills, only suggestions to make simple movements possible for anyone—shaking wrists, or swinging legs, or rolling hips. No formation lasted more than a few minutes, for these excitable patients have no longer concentration span than a three-year-old. Sometimes a dozen women, sometimes only three or four, moved rhythmically together in a circle. Some twirled and whirled all by themselves, or with imaginary partners, outside the circles. At times there were dancing pairs. A pale thin girl with agonized eyes turned a chair towards the wall and sat in it with her back to the moving figures during most of the session; then suddenly she jumped up and bending and leaping to calypso music joined the others. Shortly before we left, a white-capped attendant came in with a fresh supply of towels; spontaneously and lithely she fell into lively stepping; a patient put an arm around her waist and the two of them danced merrily away together. It was all only a little mad, and very gay. No one got into a fight, although the number of women in felt slippers and one with patches on her face evidenced kicking and scratching could be anticipated. Not once did I hear the screams or tirades or shrill conversations with voices typical on such wards. The only loud sounds were the laughter of women who seemed to be thoroughly enjoying themselves.

On the surface, the session seemed like merely free-for-all activity, apparently aimless recreation. But important things had happened to troubled minds. Through moving to music—"And that's all dancing is," says Marian Chace—the patients had healthfully released sick anger and hatreds.

One heavy-set middle-aged woman, for instance, who did nothing but pace during the beginning of the session started vigorous bending movements in time to a lusty tune.

"Scrub, scrub, scrub," she chanted.

Marian Chace made similar movements alongside her, and chimed in with "Scrub, scrub, scrub" too.

Continuing her rhythmic bending from the waist, the woman held out her arms and simultaneously took big forward strides. Again Miss Chace, beside her, adapted her

pantomine. "Scrub, scrub, scrub, and pushing a baby carriage," the woman remarked. "You can do it at the same time."

Next she moved her arms round and round. "Sometimes you stir the food," she said. Then suddenly she urged, "Put your head on my shoulder."

Marian Chace did so. The patient put her head on Miss Chace's shoulder and grasping her around the waist held her close. Responsively Miss Chace put her arm around the patient's waist and the two of them moved up and down together, up and down, each time going lower with each downward dip until they were nearly lying on the floor. For a moment I was terrified; I thought that the large, irresponsible former housewife was going to choke the dance therapist. But the minute the music stopped she broke her hold, stood up very straight and tall, grinned broadly and exclaimed, "Golly, isn't that a relief!" Indeed, her mood remained so amiable that she escorted us to the end of the corridor as we were leaving and, turning to me, graciously complimented me on being such a beautiful dancer—although I hadn't left my chair.

Later Miss Chace interpreted for me what had happened. "She was acting out her hatred of domestic drudgery. When she said 'Isn't that a relief!' she meant that she had been close to someone who understands her problems and feels as she does. A few times more of releasing through body-action the feelings she's still too sick to put into words, of wordless assurance that she has a congenial friend, and she'll be accessible to verbal psychotherapy with her doctor."

On wards where men or women are depressed and withdrawn, too quiet rather than too active, there is little similar, spontaneous plunging into expressive movement. Here Miss Chace has to draw out, woo, induce participation in even such simple activities as taking slow easy rhythmic steps. But wherever she holds the dance sessions she uses the sequence of rhythm, movement and touch.

On a ward of depressed women, sitting with their eyes fixed on nowhere, standing still and stiff against the wall or crouching dismally on the floor in doorways, as far away as they could get from everyone else on the ward, the first records Marian Chace plays are attuned to the prevailing sad slow mood. Then she begins to circulate about the day-room, gracefully undulating, swaying, as she approaches one silent sick individual after another. With a warm, gentle "Won't you dance with us? We need you," or wordlessly, she holds out her arms, not high, so they do not seem threatening. I saw woman after woman begin stiffly and tentatively to move rhythmically too, then put out her hands and timorously, slowly place them in the dance therapist's.

As a step toward recovery a mental patient's willingness to hold hands can be as momentous as a baby's first word in the process of growing up. "Psychotics don't want to be touched" is a truism in mental hospitals. "I never take patients' hands," says Marian Chace. "I let them take mine, when they are ready through their response to music and movement."

And she can tell when they are ready, she maintains, not through second sight nor some mysterious kind of intuition, but because of her training as a dancer. As all of us can judge roughly the way normal people feel through their facial expressions or tone of voice, so she can gauge to a fine point whether or not patients want to make contact with her by their bodies, by the way they sit or stand, pull back a little or lean slightly forward, whether their muscles are tense or relaxed.

Observing her at work, questioning her, learning from her, with her permission I

tried out for myself some or her wordless technique of invisible wall break-through. The first time, on a men's ward, I started out all right but then made a mistake. I managed to draw into the dancing a middle-aged man, very busy shaking his fist at his voices and moving his lips silently at them. I had swayed before him, a little distance away, holding out my hands in wordless invitation. The fist opened and he placed his right hand in mine. Then his left hand which had been up in the air, moved slowly down to my shoulder. I neither drew back nor moved forward, thus communicating—as I had learned from Miss Chace one must—that I was neither fearful nor trying to impose myself on him. Apparently he felt safe, for his other hand moved into mine too, and I had a moment of triumph when we did some simple steps together. But it did not last long. All of a sudden the hands pulled away, not angrily, only in a gesture of "Leave me alone now, I've had enough," and he returned to acting on his delusions.

"What did I do wrong? What would you have done?" I asked Miss Chace later.

"From reading and experience I'd have known he was too sick to sustain any but the briefest contact," she said, "but even if I hadn't I could have told by the tension of his handclasp when it was time to leave him before he left me."

Next time, on a woman's ward, I was able to do better. The patient was an angry-looking woman who when we entered was cursing and shouting furiously, "They've been sticking pins in my behind!"

Marian Chace promptly adapted her mood. "Well," she said indignantly, standing hand on hips, belligerently before the patient, "that's what they did to you, did they!"

Somewhat mollified by this evidence of fellow-feeling, the patient retorted a bit less angrily, "They sure did!"

"Well, it must have been good for you, or they wouldn't have," Marian Chace continued casually, "and dancing will be good for you too, so won't you do it with us?"

Without another word the woman arose, put her hands in Marian Chace's and started a stately minuet-type dance. Freeing Miss Chace to get in other dancers, I took her over. I had learned that one does not attempt to determine the type of dancing; one goes along with what the patient indicates. So we held our clasped hands high, pirouetted gravely and made deep curtsies to each other like two grand ladies. Dignified, and wordlessly accorded dignity, the patient's hostile expression changed to one of serene and lofty satisfaction, and everything seemed to be going fine until I felt her hand begin to tighten around my wrist. I dropped it promptly, leaving her free to go stepping off by herself, and we therefore remained friends. Much later in the session, in the midst of releasing anger by banging the palms of her hands savagely on the floor in time to lively music, she paused for a moment to give me a good-natured wink.

The first few patients are the hardest to get started. As the sessions go on a kind of contagion develops, and more and more join in unasked. Miss Chace bides her time with those who remain aloof through two, three or more sessions; she never urges, is never importunate, never puts anyone in the position of seeming to turn her down. In this permissive atmosphere, a softening-up occurs even in those most fearful, most locked-in, most suspicious. One old lady, after weeks of silent watching, finally entered the hand-holding circle. "I'm glad you're with us," Marian Chace welcomed her. "Why, Miss Chace," the old lady

answered reproachfully, "I've been with you all the time!"

The difference between two sessions on the same ward, a week apart, was amazing. At the first, only about a dozen danced at all, never more than three or four together. At the second, not only were there more than twice as many participants, but a group spirit had been born. The patients were clearly more aware of one another, at times reaching for each other's hands, getting hangers-back into the circle.

I attended a dance session for women with whom Miss Chace had worked more frequently. There I had the sense of a group which had really jelled. Most of the women danced as if they felt common aims and interests and companionship.

Many of this "Dance Group," as by their own wish they are known, are young schizophrenics who realize that they are maladjusted, consciously want help, but can't take straight, super-imposed advice. They tend to talk in a roundabout way rather than directly, in poetic symbols rather than in facts. For instance, to convey that she is troubled, a girl may say, "I'm in a boat, rocking in rough water" or that she is disastrously inhibited, "You can learn a lot from babies—they're all exposed; they don't hold anything within themselves." With indirection similar to theirs Miss Chace uses words as a supplement to body action.

For instance, when she wanted the group to realize that they had mastery over their bodies, would feel more self-confident if they acted more self-confident, she played a tango record and told how Argentinian girls are taught to stand straight and proud. "Now let's be like Argentinians," she suggested. Hunched shoulders straightened, dejected heads went high, as the women adlibbed to the music. "Humph," one of them remarked, "we're from a depressed and suicidal ward, but we certainly don't look it now, do we?"

To a stimulating tune Miss Chace said, "Make your hands into fists and then let go!" Most in the circle hit out energetically at an invisible antagonist, but to one, moving her arms inwards, she commented smilingly, "Why beat yourself?" And she subtly gave insight into other unuttered feelings through a neck-bending exercise. "Way back," she urged. "Oh, way back! Fine! Some people are afraid to put their necks back—they feel vulnerable." Another dance movement, to a waltz, involved wide sweeps of the arms. "Take love into yourself," said Miss Chace, dancing as if she were doing exactly that, "then you can give it out again."

She continually encourages the group to make its own interpretations of bodily motions with such questions as "What does this remind you of?" or "What shall we do now?" "Walk through a large room, to people you like and who like you," a slender blonde proposed. "All right, go towards those friendly people," Miss Chace took her up. "Walk not thinking of yourself but of them. That's it! Good! Funny how differently you move when you really want to get somewhere, isn't it?"

Out of the Dance Group has developed group dramatics. The patients always determined their own dance activities, like parties or decorating the dance room. But even so in the spring of 1954 Miss Chace was somewhat startled, after having been away two weeks, to be greeted with a new kind of request.

"We want to do a show about a group of women living together and the funny and painful things that happen to them," the girl acting as spokesman for the group announced. "Since we're all living together

in a mental hospital, we want to do it about that. We can dream, too, and we do—and since our dreams include men, of course, may we invite them to join us?"

The outcome was a patient-written, patient-produced and patient-acted satire with music and dancing, "Hotel St. Elizabeths." It had five pairs of scenes, the first showing the realities of hospital life, like the lack of privacy in a dormitory, the second wishful thinking—a luxurious boudoir, complete with lady's maid and lover. Popular songs were parodied:

"I hear voices and there's no one there
I see visions floating in the air
I have nightmares in the daylight glare
I wonder why, I wonder why.
Schizophrenia is new to me,
I'm a double personality
Doctors say one's enough for me,
I wonder why, I wonder why."

and "We are poor little girls with our minds awry."

The group did its own encouraging. One woman, with consummate patience, taught an awkward man to tango with her. It also did its own disciplining. The group won over and toned down a difficult male patient who had been ejected from every hospital recreational activity; he always wanted to be the whole show and in the band, for example, had insisted on playing so loud that he drowned out everyone else.

Other patients besides the cast took part in the production. One girl who had sat aloof at rehearsals after two weeks offered to be script girl and made many helpful suggestions. Old ladies on geriatric wards made leis for a Hawaiian scene; costumes were sewed in the occupational therapy workshop. Altogether, so successful and therapeutic was the project that the hospital administration requested the Dance Group to create a pageant on the life of Dorothea Lynde Dix, St. Elizabeths founder, for the centennial celebration in May 1955.

For months beforehand the St. Elizabeths Players—as the Dance Group now chose to call itself—worked, together with many other patients from various wards, on an ambitious production, "Cry of Humanity." Part play, part pageant, part ballet, running three hours, it held successive audiences of invited distinguished guests, patients, patients' relatives, the Mental Hospital Institute and the general public spellbound. Moving, remarkably dramatic and finished, it portrayed patients' own interpretation of Dorothea Dix's life and works and the problems of the mentally ill. They themselves, under Marian Chace's direction, did the research, wrote the script, structured the ballets. They chose the cast, after try-outs; they made the scenery and costumes; they scrubbed the stage.

Some of the cast were under indictments. Some, when they were off-stage, conversed volubly with their voices. Few were allowed to go about unattended. Old-timers from a male chronic ward formed a chorus. The cast was constantly in flux as substitutions were made for those who left the hospital to go home. Yet through the whole long period of preparation and seven performances, I was told, there was less bickering, fewer emotional upsets or untoward incidents, than in the course of the usual amateur show.

On May 15, 1955 scenes from "Cry of Humanity" were televised from film on the March of Medicine program. One was Dorothea Dix's visit to the jail where she first saw demented, half-clad, half-starved women kept in cages like wild animals; with chilling realism 20th century patients enacted what they would have been in the 19th. One was a ballet of her dreams, another her impassioned plea to the Massachusetts legislators. During the shooting

the patients' endurance and composure never flagged for long, grueling days. Over and over they had to be under blinding lights, repeat the same lines, keep quiet when necessary. This self-control, this working together for a common end, came from people so turned in on themselves, so unable to give and take, that they needed care in a mental hospital!

"And it all grew out of dancing," says Marian Chace. Other patient-conceived and created dramatic and dance productions, under her direction, followed "Cry of Humanity." "The Skitsofrolics" was a satire on various phases of hospital treatment. In "Free Horizons," first presented May 1, 1957, the theme of mental illness was broadened to that of loneliness in the outside world; the protagonist is a Hungarian seeking the place in the United States where he will find himself at home. After this, Miss Chace says frankly, she does not know what the patients will develop as they literally move towards health.

Indeed her whole life has been a progression of one thing leading to the larger next. A successful concert dancer and choreographer, she never expected to be a full-fledged staff member of a mental hospital's psychotherapy branch.

Marian Chace was born in Providence, R. I., in 1896, of an old family with intellectual and Puritan traditions. She attended Brown University, then moved with her family to Washington. There she met and fell in love with a handsome young dancer named Lester Shafer, who urged her to study where he did, at the Denishawn School in New York. Ruth St. Denis and her husband, Ted Shawn, its directors, taught all forms of the dance except tap and ballroom, and the school was ascetically dedicated to the art of the dance. Students had to eat frugally, keep regular hours, were not allowed to smoke or drink.

Marian loved to dance, and together with Shafer to create dance forms. Offered a vaudeville tour, they decided to make it a wedding trip and then settled in Los Angeles, where their golden-haired daughter was born. Six weeks later Marian was dancing again, and soon afterwards she and her husband went on tour with the Denishawn dancers as part of the Ziegfeld Follies. Beautiful, and wearing costumes well, Marian served as a show girl besides dancing with the Denishawn troupe. Even after the couple had opened a Denishawn branch in Washington, she remained a performer, a creator of dance arrangements, rather than a teacher. She taught primarily to develop skilled dancers—some of whom went on to Broadway—to dance before large audiences with her.

Many students continued to come for lessons, however, who lacked the stuff to become artists, would never make the grade as professional dancers, and knew it. She began to wonder why. What satisfaction did they get from dancing? In 1938 she got an inkling of the answer. Shafer and she had been separated; she was continuing the school alone and was engaged, as a kind of frill, to give weekly dancing lessons to children in a Maryland boarding school. Most of the youngsters were from broken homes; they were upset, maladjusted, obstreperous. Miss Chace noted that hair-pullings, crying and rudeness stopped almost miraculously during group dancing; that often the most rebellious child, feeling he had a part to play, had leadership qualities before used only for mischief-making. Interest in the emotional values of dancing led her to volunteer the next summer at the National Training School for Girls, the next at an orphanage.

Nevertheless others recognized her unique therapeutic skill before she realized it herself. Her school began to be known as a

place where you could dance away difficulties. Pediatricians and orthopedists whose own little girls had been in her beginners' classes sent small patients to become better adjusted emotionally, to improve in coordination. Jittery government workers attended evening classes to relax and gain self-confidence. A lawyer danced himself out of stuttering. In 1939–40 Miss Chace was asked to conduct a seminar for D. C. teachers of exceptional children.

Her move to St. Elizabeths in 1942 was almost a happy accident. "I think you'd be wonderful with mental patients," said the mother of one of her child-pupils. "Have you ever worked with them?" Marian Chace said no, but she'd love to try.

She began as a part-time volunteer with the Red Cross. Very quickly she had such astounding results with patients that she was spotted as providing not merely recreation but a true though unorthodox form of psychotherapy, and in 1944 she was asked to come full-time on the Red Cross payroll. Giving up her school with a pang, except for one advanced class which she retains to this day, she devoted herself to psychoneurotic veterans. In 1947 Red Cross funds were cut off. But Dr. Winfred Overholser, St. Elizabeths progressive superintendent, wasn't going to let Miss Chace go. He transferred her to the regular staff payroll.

Neither Dr. Overholser nor anyone else could tell me how many of the hundreds of men and women who after an average stay of less than a year and a half leave St. Elizabeths each year to live again in the community owe their discharge directly to Miss Chace. St. Elizabeths affords many other treatments besides dance therapy—among them drugs, verbal group psychotherapy, occupational and recreational therapy, hydrotherapy—and it is impossible to evaluate the contribution of each. "But I *can* say this," Dr. Overholser declared. "Marian Chace has made the initial dent in many, some of them resistive to all other forms of treatment."

Today at St. Elizabeths dance therapy is one of the first activities offered to new patients, and with the psychiatrists Marian Chace participates in staff conferences. Since she has been at St. Elizabeths she has studied at the Washington School of Psychiatry. She teaches nurses, psychologists, student nurses and student chaplains as part of the hospital's training program.

Many other mental hospitals—state, private and VA—have invited her to demonstrate for them. She has taken part in numerous national psychiatric and music therapists' conferences, has spoken on dance therapy before audiences with strings of degrees, written on "non-verbal communication" in learned journals.

Others, says Miss Chace, can learn to do dance therapy; women who have trained with her have already launched it in state hospitals in Iowa and Colorado, at the VA Hospital in Battle Creek, Mich. One must, in the first place, be a dancer; otherwise, on the one hand patients will react adversely to the therapist's lack of bodily control, of flexibility, of balance, of easy movement, and on the other the therapist will be unable fully to recognize the significance of their movements, detect slight, unobvious muscular tensions. Second, one must really like people and accept them as they are, meet them always with respect, as equals.

But even without the services of a real dance therapist, she says, tens of thousands of patients now deteriorating in wretched idleness in mental hospitals all over the United States would benefit by regular dance periods arranged by nurses and attendants. All they need to do is to play dance music, indicate their own readiness to dance, and let the patients engage in free

movement, for a little while to feel joy and peace.

In fact, Marian Chace believes from the bottom of her heart and experience, we'd all do well to get over the repressions, the inhibitions, the self-consciousness which our civilization has put on the impulse to make rhythmic movements, to dance. "Why does practically everyone look sheepish when I ask, 'Do you ever turn on the radio or phonograph and dance when you're all by yourself?' " she says with a twinkle in her eye. "After all, our most easily available, least expensive, freest means of healthful self-expression and emotional release are our own bodies."

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Using community agencies in the treatment program of a traveling child guidance clinic

A traveling child guidance clinic which functions only two days a month in a distant rural community certainly cannot operate in the same manner as a permanently located clinic. Upon this simple truth may rest the difference between the failure or success of a traveling clinic. Staff members of permanently located child guidance clinics frequently find their ingenuity tested in a shift from the comfortable daily routines of an established situation to the vicissitudes of pioneering.

The authors are in the Utah Child Guidance Center and departments of psychiatry and pediatrics of the University of Utah College of Medicine. Their original clinical investigations were supported in part by grants-in-aid from the U. S. Children's Bureau and the division of maternal and child health of the Utah State Department of Health. This paper was presented before the March 1956 meeting of the American Orthopsychiatric Association.

In the spring of 1954 the staff of the Utah Child Guidance Center was called upon to establish a traveling clinic for the four southern counties of Utah. The center in Salt Lake City was organized within the departments of psychiatry and pediatrics of the University of Utah Medical College to provide psychiatric service for children from all parts of the state and from bordering states lacking similar services. Until recently it was the only full-time adequately staffed child guidance clinic in the Intermountain West, a vast geographic area extending from the Rocky Mountains to California. This lone unit attempted to provide psychiatric service wherever needed, but to receive help it was necessary for the child and his parents to come to Salt Lake City. For some this meant a round trip of 700 miles.

It was not too difficult to accomplish psy-

chiatric evaluations of children no matter how far the distance. Appointments for psychiatric examination, psychological testing and social work intake procedures were arranged so that a fairly complete study could take place in a brief period of time. The patient and his parents stayed at a convenient motel during the 2-day evaluation sessions. Then the patient's problems were discussed with the parents and suggestions were made for parental and community help. Treatment on a regularly scheduled basis was usually impossible. Economic limitations and adverse forces of nature seem to make impossible a weekly treatment regime when round trip travel of more than 200 miles is involved.

Obviously the great need of this area was for strategically located child guidance clinics which could provide treatment as well as evaluation services. For this to become a future reality, any beginning projects with a part-time clinic would have to be well planned and well executed so that its worth would immediately be recognized and acknowledged. The value of a clinic is measured in terms of treatment successes, not diagnostic or evaluative skills.

In our southern Utah venture we were impaled upon this dilemma. To succeed we needed to treat. Treatment of children on the basis of one psychotherapeutic session per month is generally considered ineffective. Now it became painfully apparent that a traveling clinic must operate differently. Perhaps our approach to treatment would have to be drastically revised.

If *we* could not treat then it might be wise to enlist the aid of all available community agencies and facilities to carry on "treatment" in our absence. Our Colorado neighbors, the real pioneers in traveling clinics (1, 2), found community cooperation to be of crucial importance. Maybe we would be able to treat if we could make psychotherapeutic "aides" of the people who would have most contact with the patients from month to month.

Although the first clinic session was not to be held until September, in July the traveling team made a trip to the major city in southern Utah to meet with representatives of the various towns and counties of the area. The executive committee of the Southern Utah Mental Health Association became the local organizing sponsor, with the local public health nurse playing a key role in scheduling the meetings. Representatives of the schools, churches, social and legal agencies attended. Also present were public health nurses, physicians and interested citizens. A representative advisory board was organized to advise on policy and program.

In our preliminary meetings we first tried to find out what these citizens expected a child guidance clinic would do for them. Although they had no well formulated ideas of clinic functioning, each one reported a need for help with particular child adjustment problems.

We described the varieties of personality problems with which we might be of most help. To orient and to revise realistically the community's expectations about what we could accomplish, we carefully explained *why* we could be of little direct help, for example, to the mentally retarded child or to the confirmed anti-social character. With the settling of some technical details, the traveling clinic became a reality.

In the September clinic few patients were seen; most of the time was reserved for the people who would have close contact with the patients in our absence. Live examples were now available and specific, concrete suggestions could be made. For example, we talked with a teacher who was at her wit's end over a child who constantly seemed to disrupt her 2-grade class with

"dirty" talk. When we agreed that such behavior was intolerable in a classroom situation, she began to tell us how she might cope with the problem. Time and again there were situations which we felt no teacher should be asked to tolerate. Sometimes we felt we were merely endorsing and supporting commonsense but the effect of sympathetic encouragement was often remarkable. Time and again teachers rose to the challenge with solutions to problems which left the clinic team feeling humble.

Because of a limitation of funds and personnel and because of our desire to work closely with community agencies we decided initially to start with an incomplete psychiatric team. While we were aware of the considerable lack of trained social workers in this sparsely settled area, we knew that the public health nursing service was well organized and efficient. It was decided to use this group and the very few public welfare workers as our principle liaison with the community. With this local nucleus it was felt that a psychiatrist and a psychologist might afford the most effective service. This abbreviated team wished many times for the services of a trained, skilled resident psychiatric social worker.

Both the psychiatrist and the psychologist needed to make definite shifts in their usual clinical approach. Each began to assess his own effectiveness with the critical eye of an efficiency expert. Usually the psychiatrist saw the parent or parents for an hour intake to supplement the historical data already obtained by the public health nurse; at the end of this time he expected the psychologist to provide verbally an evaluation of the child from his test findings. To do this the psychologist had to make a rather drastic change from his lengthy and leisurely testing procedure (3). Fortunately the psychiatrist and the psychologist had worked together closely for four years and did not find excessive these demands for rapid evaluation and communication. During these brief conferences they made tentative treatment plans subject only to the later modifications which might arise from the psychiatrist's evaluation of the child. Then alone, or with the psychologist, the psychiatrist acquainted the parents with the findings and gave them counsel. The results were discussed with the teacher and suggestions were made for coping with school problems. If the public health nurse could play a role in the total situation, her assistance was solicited. In a like manner any person in the community who might be of assistance was sought out and pressed into service. The decision for further psychotherapy sessions was also made at this time.

A brief case report might best illustrate our working procedures: Connie, a pretty 15-year-old girl, was referred to the clinic in March 1955 by her high school teacher who had noted that she was daydreaming a great deal and that her school work was beginning to suffer. It was reported that she was withdrawing from social contacts. She was brought to the clinic by her foster parents, who demonstrated some annoyance that they were being involved.

On the first visit the psychiatrist saw both foster parents in a joint session and then each one separately. In giving the history the foster mother carried the conversation. She demonstrated considerable ambivalence about keeping Connie, pointing out her numerous faults, many of which appeared to be well within the "normal adolescent" range. It was learned that Connie had been taken from her mother about five years before because her mother was considered an unfit parent. Her mother had been divorced earlier from an alcoholic husband. Connie was placed in a series of foster

homes for periods ranging from two weeks to 18 months. In each instance but one, the moves were made because of conditions in the foster home and not because of the behavior of the child. Two years ago when another foster home failed the present foster parents were prevailed upon to take Connie into their home. Connie's older brother had lived with them from the time the court took the children from their mother. Connie's stay had been on a "temporary" basis, subject to the social agency's success in finding another home for her. The family constellation, then, was made up of the foster parents, the patient's older brother, the patient and a 10-year-old foster sister who had been adopted as an infant by the foster parents. It was because of this daughter that the foster parents did not take Connie when they took her brother.

The foster mother's chief concern seemed to be that the community might think poorly of *her* because of Connie and her background. The foster father expressed the feeling that his wife was unduly concerned. He felt they were helping the girl and that despite his wife's vacillation they would keep her since they both liked her. The foster mother appeared to resent the ease with which her husband achieved his understanding of Connie.

In the three succeeding monthly sessions with the foster mother she was helped to see how her own emotional involvement made her over-sensitive to community opinion. A more realistic appraisal of the situation made it apparent that the people she knew felt she had helped the girl and admired her for it. The mother gradually began to understand better the meaning of some of Connie's behavior. She could see that Connie's rebellion and acting out reflected both her interest and security in the home as well as her difficulties. She could accept Connie's threats to leave as tests to determine whether she was really wanted and loved.

There were no contacts during two summer months. In the fall the foster mother reported great improvement in the home and in the patient's social adjustment. She reported that she had informed the 10-year-old that Connie would live in their home as her sister. She wished to discontinue therapy but asked for the privilege of returning if the need arose.

We must now go back to the occasion of the initial visit to pick up the procedures with the clinic patient. Connie was seen for diagnostic testing by the psychologist while her foster parents were being interviewed by the psychiatrist. Her flat and almost bland behavioral response to the testing situation was paralleled by the autism and fantasy preoccupation manifested in test responses. Marked schizoid tendencies along with indications of increasing withdrawal and accompanying depression suggested a poor prognosis for averting an overt adolescent schizophrenic episode under the treatment program of a traveling clinic. Long term intensive psychotherapy seemed to be indicated.

In consultation with the psychiatrist following testing it was agreed that her condition was serious but that her adolescent life situation and an intense resistance to the clinic experience may have obscured in the testing some of the strengths contained in the history and manifest in the brief psychiatric interview. Since intensive psychotherapy was unfeasible anyway and hospitalization seemed premature it was decided that the psychologist would see her in monthly therapy sessions. The decision was supported by the feeling that the parents could be guided toward providing safe circumstances for her until our next visit.

Connie kept her appointment the follow-

ing month with no apparent increase in withdrawal. She filled her first few therapeutic hours with complaints that her foster mother never allowed her any privileges, that she required inordinate amounts of household responsibilities of her and that she disciplined her unreasonably and capriciously. By comparison she pictured her foster sister as never being punished for even more serious infractions of rules or for neglect of her duties in the home.

Surprised that anyone would take her complaints seriously, Connie began speaking cautiously and then with remarkable candor about her own feelings in recent and disturbing home incidents. Monthly interviews spontaneously took on striking continuity. Discussions focused around her uncertain feelings concerning her status in the foster home. In a very short time Connie was able to make surprising use of the idea that her complaints were her way of voicing her fears that she was unwanted and unloved by her foster mother. She could see that her rebellious behavior might be a measure for testing the depth of her foster mother's tolerance and love. Connie's foster mother soon had fewer complaints and Connie was again participating in social activities.

The child welfare worker responsible for this girl's placement was absent from the community during our early contacts. She returned about the same time that we resumed autumn clinic visits. She renewed her usual weekly contacts with Connie, and Connie continued with her monthly clinic visits. In regular supervisory hours with the clinic team the child welfare worker was guided and supported in her efforts to develop a better therapeutic relationship with Connie.

We call this a treatment success. Fortunately, most of our first efforts were successful. We meant them to be. How can you sell the value of a child guidance clinic if your record is loaded with failures? We were pleased to hear reports of better adjustment patterns in most of the children we were seeing. The gratitude of parents was expressed directly and indirectly. Our community "aides" reported positively upon most of our patients. At the spring 1955 meeting of the Utah Mental Health Association the representative from southern Utah reported the findings of her personal investigation of the clinic. She was probably liberal in her conclusions of definite improvement in every case.

It may be well to examine the factors which we feel may have helped this project to succeed. From the experience of Coleman and Switzer (1) we could have expected to fail. They found: "In the absence of any trained social worker in the local community, the functions of the traveling clinic soon become restricted to diagnostic appraisal, the therapeutic results are seriously reduced, and there is very real question as to whether the gains obtained are worth the effort expended." To our delight and,to some extent, surprise Connie and many others like her make us feel that our efforts have definitely been worth while. We attribute our success in many ways to what we accomplished in *training* school teachers, principals, public health nurses, sheriffs, a juvenile court judge and "plain" citizens to substitute in a variety of ways for the much desired psychiatric social worker. We say *trained* rather than *oriented* because we feel that what we did with skills already available is now a permanent and *functioning* community asset. We attribute our success in this training venture largely to the attitude we took toward community personnel. Our procedure was simple enough. We mobilized all of our own clinical skill in an effort to make it as easy as possible for the

people in the community to show us what they could do on their own.

The senior clinical team would like to think its skill was of some importance. This they cannot claim. After about six months a junior team composed of a senior psychiatric resident and a junior clinical psychologist joined the traveling clinic staff. In just a few months they became as effective a team as the senior combination. Now the senior team feels confident in withdrawing and in leaving the job to their so-called juniors. The confidence of the community in their successors removes any disadvantages which may go along with "juniorism."

The waiting-list may be seen as ample evidence of the continued need for psychiatric service for the children of southern Utah. That the service will continue seems to be almost guaranteed by the increased community interest. The people of this area are moving rapidly toward their goal of a child guidance clinic of their own, chiefly perhaps because they were helped to see that this venture was largely their own undertaking.

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Aspects of the use of art in the treatment of maladjusted children

As it becomes increasingly apparent that the effective treatment of maladjustment depends ultimately upon the ability of the therapist to understand, to recognize and to utilize the distorted and disguised functionings of the child's unconscious, so is it becoming an important part of orthodox technique to use art in diagnosis and therapy. Unfortunately there are still institutions which appreciate the need for counseling and for more or less intensive psychotherapy or psychoanalysis but which confine art to the place of a hobby or distraction—an evening activity in competition with other evening activities. Or worse, restrict it to a few periods on the lesson time-table. It is indeed odd that an activity that canalizes much of the disturbed child's aggression and nervous energy at small cost should be so neglected in the ceaseless search for active techniques.

"That process of teaching man to see himself . . . is the supreme function of art," according to Maynard (1), and it is furthermore one of the essential aims of psychotherapy. Briefly, the diagnostic purpose of art is to provide an *indirect* means for the child to reveal his conflicts or unconscious problems. In this it approaches the fundamentals of play therapy. The therapeutic value of art is in its power to offer the child a means of abreaction or catharsis which is also creative. In this it is analogous to such techniques as psychodrama.

At Red Hill School in Maidstone, Kent, art has been a major therapeutic and educational technique since the school's found-

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ing in 1934 by its present principal, Otto L. Shaw. Red Hill School is a residential grammar school recognized by the Ministry of Education for the education and psychological treatment of 45 boys suffering from problems of emotional and social adjustment. Child guidance clinics, children's departments of local authorities, hospitals, juvenile courts and probation officers refer to the school those boys who suffer from stealing, aggression, running away, sexual disturbances, enuresis, speech difficulties, obsessional and anxiety neuroses and like disorders, for which most of them would have been treated at local child guidance clinics were they not from homes in which they were in danger of considerable or permanent damage to their personalities.

There is no fixed period of stay at the school but it has been found that the optimum time to consolidate a cure and finish the pupil's education is about four years. No boy is accepted unless his intelligence is very superior; there is now no boy in the school with an IQ of less than 120. At the end of 1953 the mean IQ was 132.5. The average age is over 14, the age range from about 11 to 17. There is a large group under 14. New admissions over 14 are rarely accepted.

The principal is a full-time lay psychotherapist working within a complex, evolved and elaborate democratic social system. The school is almost wholly governed by a court administered by the pupils. The running of the majority of day-to-day affairs is managed by elected and community-supervised pupils' administrative committees. The court and the committees are practical working organizations —and no meretricious façade. They have inevitably a significant (if discreet) role in the school's general psychotherapeutic set-up (2).

Because the educational process is no less inextricably interwoven with psychotherapy, the members of the school's staff must be skilled in both the art of teaching and in the principles and practice of child psychology and psychotherapy. In particular, they must accept and tolerate the role of parent-surrogate—with the affection or the hostility by which it is colored—and must fully appreciate that there are endless situations in which negative or positive transferences arise to be handled as clinical and not as disciplinary problems (3).

Art plays a considerably larger part in this school's educational time-table than it does in a conventional grammar school. The pupils are encouraged to use the art rooms after lessons. This is not a privilege for the good or the particularly artistic boys but is one of the amenities provided by the community for its members. It is perhaps misleading to write of "art lessons," because there is no attempt at formal training or instruction. Art is regarded as a completely individual and spontaneous activity. In one lesson a boy may be molding a papier-mâché mask for his costume for the Halloween party, a second may be painting a still-life in oils, a third carving a lump of rock or chalk, a fourth designing a mural and several more drawing or painting in oils, gouache, pastel, conté crayon or crayon—whatever their fancy takes.

It therefore follows that the teacher of art must be primarily interested in the personalities and problems of the individual pupils and must only as a secondary consideration regard himself as a technical adviser or even as a teacher of art appreciation. This does not imply that a highly qualified child psychologist is a potentially better teacher of art in a school for maladjusted children than is a trained art teacher—even if the latter is not unenlightened. Besides those intangible per-

sonal qualities which make one adult more imaginative in the subtle alchemy of human relationships than another with equally satisfactory professional qualifications, the enlightened art teacher by virtue of his training has one special asset: the knowledge of methods and techniques. Art is no satisfaction to the boy who does not know *how* to chisel his puppet's ears, nor how to paint the devil that he visualizes, and who senses his inadequacy; the boy's technical inability is a further annoyance and frustration. The art teacher should be able tactfully and skillfully to show the pupil how to turn his fantasy, his idea, into a painting or model. When called upon—and not until then—the teacher must be ready to advise on method or technique. The trained teacher has a wide knowledge of media and styles upon which he can draw for suggestions to the pupil who wants a change from his latest style or interest. More important, such a teacher can offer an ultra-suspicious or disinterested boy so wide a variety of art possibilities to play with that he cannot but find something to capture or stimulate his latent interests. The teacher, in making his suggestions, must rigorously avoid any conscious bias or selection of subject; he is well advised if he speaks in the most general or even deliberately vague terms. By the time the teacher has expressed a few sentences and a pretense at pondering has been made, the boy has often revealed that he is seeking approval for *his* idea—rather than fishing for the suggestions of the adult.

Many children can start work freely with little encouragement or need no encouragement at all. Some have so many ideas that they cannot find time enough to finish any one of them adequately. Others are inhibited, timid, afraid to betray their problems and afraid lest they are unable to reach perfection in an activity so dependent on their own efforts. Most maladjusted children have extremes of productivity and sterility. A small but significant group are the sophisticated children who seem to have a flair for producing, without stint, paintings and drawings teeming with symbolism.

The teacher has to be a catalyst and must suit his stimulation to each boy individually, taking care not to project his own unconscious fantasy into the work of a pupil by subtle suggestion, pressure and approval of which he is only half aware. It is no less necessary to guard against the creation of an unduly high (and therefore discouraging) standard of technical achievement. If art is to have any value to the psychotherapist and to be enjoyed for its sake by the pupil, then the pupil must feel that it is an activity all can attempt, however low or high their technical standard. As one of the boys commented, "I like art because even I can have a bash at it." Of course most boys are delighted to see that they have improved their technical grasp, that they can more adequately express in the form of art their fantasies, interests and desires. There is a glow in all creative achievements and no child should be discouraged from seeking it within the limits set by his imagination and dexterity. John's crude color, sketchy design and stiff form is to him as much of an achievement as Jack's slick, sophisticated and bizarre style. To compare them is as harmful psychologically as it is false esthetically.

In the school there is very wide discussion of art and the well-stocked art section of the school library is much used by the boys. There is a general catholicity of taste and appreciation and a wide tolerance of odd, strange works of art. Although Bosch, Picasso, Braque and Dali are admired by many boys, there are also many who appreciate the more orthodox painters such as Rembrandt, El Greco, Goya and Constable,

and many who admire both groups. There seems to be no tendency to copy or to imitate other boys' work or that of the library's art books. Only rarely is there a craze or a fashion. This is probably due to the intense individualism of most maladjusted boys.

Like all aspects of psychotherapy, art has a social relevance in addition to its inchoate high social esteem at Red Hill School. There is a constantly changing display of pictures, most of them in public rooms such as the library and the main hall, and others in the artist's bedroom or dormitory. The house is decorated by murals executed by the boys: a dragon guards the stairs leading to the principal's room; the main hall has two abstract murals of leaves and plants and a display of printed designs; an alphabetical fantasy faces the library door, and there are others. Other types of decoration include mosaics of bits of china, glass, wire, sticks and broken light bulbs set in cement, mobiles, large wooden carvings, colored glass windows made from broken bottles, and block-printed fabrics.

Much of this activity is formally under the aegis of the decorations committee (of which the art teacher is usually a co-opted or elected member) and provides a means whereby a reserved and artistically imaginative boy can contribute to social life and obtain a social satisfaction that he might otherwise miss. A danger in all residential communities for maladjusted children is that there is too much pressure on the child to participate in social activity and that there is correspondingly less opportunity for the reserved child either to escape or to contribute without the tensions of an assumed and synthetic extroversion. A boy whose picture is displayed, or who undertakes to paint a mural or decorate a room, is encouraged to participate in social life without strain and on his terms. His sense of his ability to contribute to that social life is thus unobtrusively increased. There is also a benefit to many boys in the indirect discipline, foresight and planning that are needed to successfully carry out a project, and the often tedious physical preparation can help an impatient and hasty boy who is intolerant of frustration to see that he *can* wait for results and that waiting is bearable.

To the psychotherapist, artistic activity has six-fold significance:

- It is a means by which the maladjusted child can be helped to progress from stages in which his main interests are destructive to those in which they are abreactive and creative, and finally to those in which they are creative and where destruction and abreaction are minimized.

- It assists the therapist to understand and treat aspects of the child's unconscious problems which the child is unable or not well able to express in words or even in play.

- It provides the child with a painless way to express symbolically his malaise which will neither bring him into conflict with society nor exacerbate his neurotic tensions.

- Through art a child can re-enter social life, or by his use of symbolism can show his unconscious readiness to do so.

- Art is a method of exploring the external world and of manipulating it experimentally in a manner that minimizes the dangers of contact with that world while giving the child an opportunity of coming into contact with it.

- Art is an activity without the high technical demands of many hobbies and sports and is much more closely linked with the unconscious motivations of the child. It can satisfy the most solitary and the most

gregarious, and give both a sense of personal achievement and personal worth.

Of most immediate interest is the problem of interpreting the boy's art, of translating symbol into reality. Harms writes (4) that "symbols used by the child . . . are merely a form of self-expression, a kind of monologue the child speaks with itself," and compares them with the adult use of symbolism as "a means of understanding about concepts difficult or . . . unsuitable to express with words." Symbols are indeed a form of self-expression, but if they are a monologue often the child does not understand the language in which they are spoken (the language of the unconscious), and this has to be interpreted for him by the psychotherapist. Symbolism has, it seems, more than one function psychologically: It is a form of self-expression. It is a means to grasp concepts or emotional states which otherwise might be expressed with shame, guilt and reluctance. It may be an escape from intolerable conflicts and pressures, an attempt to lessen the pain of those conflicts by changing them into an overt form which is less unpleasant. In artistic activity, as in dreams, this is effected by seizing upon the world of objects and endowing some of them with the charge of emotion. Thus objects which would otherwise be relatively neutral emotionally become dyed with unconscious significance. From another point of view, this is an aspect of the tendency "of the forward urge of the libido seeking to maintain its hold on the world of objects" (5).

Few psychotherapists would fall into the trap of rigidly applying the schemata of a school of psychology without considering the peculiarities of a particular patient's case. Schemes of symbolism are not formulas but diagrammatic illustrations. Only experience and insight can decide if they are relevant. If a boy uses wholly abstract symbols it may be impossible to interpret them until formal analytic work with him has progressed. Thus sinuous snake-like forms are not necessarily phallic; a pattern within a strongly demarcated border is not always a mandala. A practical danger arising from premature interpretation is that of causing the boy to dry up. If he does not have a suitably trusting relationship with his therapist and if he has not reached the stage when he can tolerate the revelation of unpleasant or repugnant unconscious material, not only will he reject the interpretation but he may also develop a negative transference. This is particularly likely to happen if a boy is a suspicious, introverted type for whom the effort of analytic confession is a sufficient burden. On the other hand, some neurotic boys are able to produce with no effort reams of paintings stuffed with analytically significant material. A first interpretation, however, of what seems to be obvious may fail to reveal material that is hidden by the superficially significant material. To such a boy, art is not a focus for his neurosis but an additional defense mechanism from which he gets secondary gain in the discussion of its content.

In a school—unlike in a hospital or child guidance clinic—it is advisable to keep distinct as far as possible in the mind of the boy the dual role of art as part of both therapy and of general education and culture. In a clinic the patient accepts art as one of the recognized techniques and feels a dichotomy between the use of art there and at school. In a school community, where so many boys are sated with psychology and suspicious of it, this is not so. Some boys feel that behind the friendly attitude of the adults lurk darker motives. Such a boy may feel, "They're watching me all the time. Why should I be friendly? I'm

not going to give myself away." Another may steadfastly refuse to become involved in any spontaneous activity including art. Art for art's sake is therefore a good policy in a school community.

If the psychotherapist wishes to make use of a boy's art, he can and should make suitable arrangements with the boy to see the paintings or drawings. This does not imply that art is used by the therapist only when the need arises in an analytical session but rather when it seems to suit the stage and tempo of the analysis. It is always possible to use the art unobtrusively—not for direct interpretation with the boy but to discern trends, if any, which the art suggests or any immediate significant features.

Despite his overtly cheerful and sociably active behavior, a boy recently began to paint sinister portraits of men, bisected by violently contrasting shades of green and with a depressed expression. The boy's daily behavior revealed no tension or depression. Analytic work with him was cautious and reassuring because of his acute suspicion and reluctance to speak about himself. The series of pictures warned his psychotherapist that the boy was passing through a temporary or lasting period of strain. This the therapist was able to deal with without referring to the pictures which had provided the clue.

In contrast, there are the boys who meticulously avoid art because of their unconscious defenses. One such boy insisted upon drawing elaborate counter-change patterns, another copied Walt Disney characters, a third laboriously drafted plans of railway engines. Each of these boys was gradually able to feel sufficiently free to express himself imaginatively and spontaneously. But not all boys are satisfied with imaginative art nor able to draw imaginatively. Some may find more satisfaction and a kind of sedation in technical achievement and precision, which is not to be confused with the artificial and strained naturalism of the boy who is seeking shelter behind his defenses.

The technique of interpretation does not differ fundamentally at Red Hill School from the interpretation of dreams: the classical association of items, analogy and the like. The high intelligence of the boys, however, often makes the content of the analytic session different from a session with less bright patients. Otto L. Shaw reports (6) that in analyzing the painting of one boy it was necessary "to recognize a misquotation from a poem in French, a mistake in a discussion of the allotropic modifications of phosphorus and sulphur—both of which then related to a conception of the analysand's of Aston's work in isotopes, and all these matters then fitted together to an unconscious expression of certain conflicts about a sexual issue." A picture is physically present and before the therapist and the boy in a way that a dream is not. This makes it possible to use the picture actively to dramatize the boy's conflicts by reference to it and by pointing out its latent content with such comments as: *"You* are the boy who is caged in by those walls" or *"You* are that executioner and *you* are executing your brother whom you hate." As in other techniques and as in all therapy, the success of active devices depends on the psychotherapist's sense of timing so that the interpretation frees and stimulates and does not shock the patient into numbness or hostility.

Most interpretation of pictures can be relatively shallow, as is illustrated by the following examples: Harry came to the school at the age of 11 with an IQ over 130 and a history of enuresis, stealing, rebelliousness, destructiveness and aggression. His early pictures included a series of different kinds of nests made of living snakes,

perched insecurely on the ends of high frail branches. In one picture, the boy explained, "The strange birds build a nest of snakes," and two birds are flying to the nest bearing in their beaks a snake to add to the nest. The boy further explained that they were a father and a mother bird and that they had to share the carrying of the snake because it was too heavy for one of them to manage. To the boy the nest of snakes symbolized his home, dangerous and impermanent. The perching of the nest on the insecure branch emphasized his feeling that his home was uncertain, a home in which his mother's promiscuity was equaled by her neglect of her children. The two birds carrying the snake represented the fantasy of a united mother and father who will *really* build a home, but this wish-fulfillment fantasy destroyed itself with a streak of reality—mother and father are not rebuilding the nest from any new and reliable foundations and materials but from the unsatisfactory snakes that the existing nest is made from.

Another boy drew a number of pictures in which a giant was attacked by little dwarfs armed with bows and arrows. The giant, who had no mouth, was armed with a massive scimitar which he was not using. In this picture the boy was expressing his resentment and hostility to his mother's nagging and dislike of him. He is the giant who does not revenge himself upon his tormentors although he has the means to do so. The dwarf's arrows represented the nagging pinpricks he suffered. In his reluctance to counter-attack, the boy's hostility had turned against himself and he suffered from acute asthma.

The sexual confusion of another boy was shown by his drawing figures with markedly feminine breasts but with beards. Still another boy, with great practical ability but with a suspicion of art, first showed an interest when he made a tableau in clay of "Burglar Bill begging for mercy." In this tableau Burglar Bill, wearing a red and black striped jersey and blue trousers (one of the boy's own outfits), was kneeling in front of and begging for mercy from a dominating policeman. Both Bill and the policeman had flaming ginger hair, the color of the boy's. The tableau was a vivid and unconscious representation of the boy's successful struggle to conquer his personal defects of aggression and dishonesty; the policeman is an almost classical illustration of the disguised super-ego.

Not rarely is the symbolism of a picture less immediately obvious, as in the case of the highly abstract oil paintings of a boy struggling with his latent homosexuality. These pictures have titles such as "Fear," "The Revolt of the Machines" and "Symphony in Brown," but the pictures are elegant, well composed and quite devoid of apparent symbols. To the untrained observer the titles sound conventional and the pictures look the work of a sophisticated and able boy. The bizarre nature of such deeply symbolic works of art, the violent emotions that a boy feels as he creates them, often impel him to reveal himself as uneasy —longing to know *why* he feels so strongly, *why* he experiences a lightening of the spirit or depression after painting them. He frequently senses a connection between his art and his malaise and will readily cooperate with his therapist in the task of interpretation.

There is also the contrasting type of boy who hides or destroys his paintings, usually with the verbal excuse that "they aren't any good anyway." It has been found that where a boy has progressed the mood or style or content of his art changes and the symbolism alters so that he ceases to repeat former significant symbols. In general, as the psychotherapeutic process continues

successfully a boy's pictures show less violence and morbidity and he shows less tendency to repeat quasi-obsessional subjects and patterns.

It is doubtful if art in itself can provide a complete and thoroughgoing psychotherapy. Unless the boy has psychotherapy or counseling he will merely tend to repeat in one or more forms in his art his basic problems and interests. This repetition becomes a habit and so is devoid of abreactive effect. The reason for this, perhaps, is that as an artist and a sufferer from neurotic symptoms and conflicts "he seeks a double compromise. Struggling to effect through artistic sublimation a balanced solution of his unconscious conflict, he nevertheless cripples those efforts by having recourse at the same time to neurotic symptom-formations which may ultimately interfere with his artistic technique, his choice of subject or both" (5). To some extent confirming this view is the observation that a cured boy does not necessarily cease to produce good art—if he was a good painter before his cure he does not cease to be one after his cure. He very probably will paint different subjects or in a different mood. The cured boy's art is leached of pathological impurities and this may improve it by releasing those imaginative energies which before were spent on exhausting psychopathological fantasy. Many boys complain that although they have the impulse to paint after they have left the school the lack of encouragement and interest in the outside world makes this very difficult.

The comparatively high artistic standard of the work of the boys is suggested by the school's three successful exhibitions at the Cooling Galleries in Bond Street and by the acceptance of works by boys at the national exhibition of child art of one of the more serious weekly newspapers. One of the aims of these exhibitions was to draw attention to the need of employing this activity in schools for maladjusted or delinquent children as much for its cultural as for its therapeutic value. If psychotherapy is successful, a boy can paint for the sheer esthetic satisfaction of painting and will be moved by "the perceptual pleasure of formal beauty" (7)—a pleasure for which a latent or overt longing is one of the distinguishing characteristics of mature, well-educated and civilized men.

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BRYANT M. WEDGE, M.D.

Developing a college mental hygiene service

It would be largely of local interest for me to outline the history of the development of the college mental hygiene movement in America. Consequently I will here discuss only some of the more general factors which work together to make such development more or less inevitable. Mainly I will mention changes in public attitudes, changes in educational philosophy and developments in the field of psychiatry.

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The mental hygiene movement flourishes only in a public climate which puts a high value on the worth of the individual. It is fairly recently in the history of man that this value has begun to be applied as a universal principle. Probably it is necessary for the development of such a luxury that man first have sufficient control of the economics of survival. Both the social and medical theory, as late as the seventeenth century, tended to explain illness and human behavior in terms of original sin. With the rise of scientific thought in the eighteenth century there was increasing interest in establishing causal relations in both the medical and behavioral fields, culminating in the enunciation of the ideas of natural selection. It is only since then, really in the last hundred years, that concepts concerning society's responsibility for its individual members and the value of the individual for himself have formed a basis

for, among other things, the development of modern public mental hygiene.

In medicine, during the same recent period, the development of application of scientific method in the 1800's led to the search for infections, anatomical and physiological causal factors for disease. Outside of certain genetic and anatomical explanations, however, the ideas of causality were little applied to cultural and personality development until the last part of the last century. It is only in the last seventy-five years at the most that the concepts of psychic determinism have been widely applied to these phenomena. Modern dynamic psychiatry rests on this concept and has enabled the physician to approach many problems for truly the first time.

The revolution in the educational world following the dissemination of methods of mass printing, particularly in the last century, has been an extraordinary event in cultural history. Within the last century and even the last two decades the idea of universal literacy has begun to have widespread realization. With literacy and wide dissemination of ideas there is an inevitable blossoming of concepts of individual self-determination. The notion naturally follows that individuals must have the right and opportunity to undertake as much education as they are capable of utilizing and able to achieve. It is only a modest extension of this notion for educators to consider all measures which might assist an individual in the educational process.

Since the beginning of recorded history there have always appeared educators with deep and sincere understanding of human nature, which they applied for the benefit of their students. Modern psychiatry has added to this an entirely new dimension, namely, a scientific approach to problems of the personality beyond the reach of the educator. From this general overview it seems most natural that psychiatry and education should join, as they began to in the 1920's, to approach and solve these peculiarly persistent personal difficulties which so often interfere with the fullest development of individuals.

It is no accident that the mental hygiene movement's alliance with education should have particular development in the colleges. Colleges receive their students at a strategic point in life, just when they are making that often crisis-ridden transition from life in the parental family to life as adults. Here the difficulties of personal development are thrown into glaring relief, and here there is still that valuable flexibility which is so important if these problems are to be resolved. Consequently the development of some educational-psychiatric liaison in 99 institutions in this country probably represents but the crude and primitive early explorations which promise to develop into an increasingly fruitful collaboration.

PRACTICAL ASPECTS

Realizing the need and conceiving the idea of a college mental hygiene service. If major medical pathology is defined as a condition which interferes with the functioning of an individual to such a degree that he is unable to carry on activities normally within his capacities it must be recognized that emotional disturbances constitute the greatest area of pathology in a college population. Now that infectious disease has been largely controlled by modern medicine, emotional disturbance constitutes the second leading cause of death among college students, following only accidental deaths. When one adds to this knowledge of causal relationships between emotional disturbance and physical disorder it would appear fair to estimate that the occurrence of emotional disturbance constitutes half of

all significant medical disorders in a given university population.

Once these facts are recognized it becomes incumbent on any university which takes responsibility for the health needs of its students to inquire what measures may be taken to prevent and correct these disorders. For the response to this inquiry the university must turn to modern psychiatric medicine. The university should then learn that these disturbances are in large degree both preventable and treatable and that the major weapon in a program directed at this problem is the college mental hygiene service.

As it happens, however, university administrations are not always aware of the nature or extent of these disorders in their student populations. The issue is clouded, of course, by long traditions of regarding emotional disturbances as moral issues to be met by will power or as the inevitable consequence of the constitutional infirmities of some members of the human race. Until university administrations are better informed it is only natural that they take recourse to the operational philosophy of the survival of the fittest when confronted with emotional failures. It is, then, the task of those psychiatrists and laymen who have knowledge of the mental health situation in colleges to enlighten the university administrations and faculties about the problem and its solutions. This is not always an easy task. Even in the United States, where some knowledge of psychiatry is extremely widespread, there exist a considerable suspicion and resistance to applying psychiatric knowledge on the campus. It is a considerable challenge to psychiatrists to demonstrate that understanding students does not lead to coddling and "adjustment" of students to indistinguishable stereotypes but rather to increased self-responsibility and enhanced mature individuality.

Securing cooperation. Securing the understanding and backing of university officials necessarily presents different problems in various institutions. The first essential in all institutions, however, is to get into personal communication with responsible officials. It is astounding to note how rapidly prejudice melts and understanding grows when the university presidents or chancellors are able to meet with actual representatives of the psychiatric field. It can be inferred from this that a great deal of the resistance that one encounters to modern mental hygiene viewpoints is based upon the widespread fantastic notions which always surround anyone who is supposed to look into the secrets of the mind.

Various methods serve to secure the ear of important university officials. One of the most effective recent developments in the United States has been the use of the visiting consultant. When the director of a health service can be persuaded to invite a consultant to survey the mental health needs of a campus it is only natural that the consultant be granted an interview with the most important officials of the university. Here a few judicious questions suitable to the purpose of the visit seldom fail to stimulate considerable interest. From this point on the official himself is quite liable to be curious enough to want to investigate the field, at least tentatively. In some instances programs have been begun following so simple a stimulus as a psychiatrist inquiring about the counseling system of a college.

Once personal communication with responsible officials of a university is established and they are somewhat aware of the potentialities of mental hygiene services the problem of initiation passes into their hands. Further development depends largely upon the readiness of the college to take the steps of exploring the field and establishing a definite service. As with our

patients, there is very little point in attempting to stuff psychiatry down the gullet of an unwilling institution; rather, one must be satisfied with exposing the institution to the idea and then waiting until it is forced to seek help because of the occurrence of incidents which can no longer be regarded as "accidental" or until further experience brings about a lessening of suspicion. Then the university officials, perhaps periodically reminded of the methods of college psychiatry, can initiate their own surveys of their mental health problem and needs. As circumstances stand today, at least in the United States, there is more call for trained college psychiatrists than there are men to fill the positions, so that one need have no haste to urge such services. One phenomenon which deserves note is the common occurrence of initial enthusiastic reception for the college mental hygiene clinic followed by a diminution in support for a service that seems expensive. Quite often as the clinic becomes more limited there comes a recognition of the real usefulness which the service had, and finally at long last realistic provision is made for a stable support. College psychiatry can then be said to have found its place on that particular campus. It is notable that practically no American university which has ever established a sound mental health service has failed to continue the unit for any long period of time.

Establishing a clinic. When a university, after due exploration and consultation, has decided to establish a college mental hygiene service its further problems boil down to two issues; that is, the selection of a chief psychiatrist and realistic plans for continued support.

Several experiences in American universities have illustrated the serious consequences of an inappropriate choice of psychiatric personnel for the college mental hygiene program. It may be salutary to review a few of these in order to illustrate the problem:

In one case, a large state university appointed a mature, respected and well-trained, descriptively oriented psychiatrist to the health service. After two years he left the work by mutual agreement, he feeling that there was no place for psychiatrists on the campus since he had seen only 37 psychotic individuals out of 17,000 students in two years, and the university feeling that psychiatry had nothing essential to offer to its students or to its functions as an educational institution. During the next four years the university developed various other devices to try to deal with emotional problems, including a counseling service on the one hand and an attitude of refusal of responsibility for any role in regard to serious cases on the other hand. Then, quite fortuitously, the university officials learned of the potential contributions of dynamically oriented psychiatry, secured a consultant who in two days on the campus was able to appreciate the educators' problem and outlined a plan for the development of a mental hygiene clinic. Finally, after a year of search they were able to find an interested, dynamically oriented psychiatrist who came to the campus to establish the beginnings of a suitable service.

In another instance, the officials of a well-endowed private college became aware of the potential role of psychiatry in the college setting. They set about finding a psychiatrist in the best possible way with wide consultation and with quite adequate budgetary backing. An extremely well-qualified man of some status and accomplishment in psychiatry was finally appointed. He did a careful job of surveying the needs of the college before expressing his authoritative opinions. Unfortunately his quite uncon-

scious authoritarian professional manner of presenting his recommendations soon served to threaten and alienate large segments of the faculty so that he finally left the college with mutual dissatisfaction. Subsequently this college brought to its campus a mild-mannered young psychiatrist with no fame at all, who has stuck closely to the clinical function and whose contributions are gradually overcoming the initial negative reaction.

In a number of instances, psychiatrists inexperienced in community work have come to feel that some special educational arrangements should be made to aid the therapeutic situation. They have then sought to make such arrangements with administrative officers, sometimes explaining the psychiatric indications for them. Sometimes the concessions which have been sought have seemed quite extreme, in terms of special arrangements, to the administrators, who have been unwilling to undertake them. This situation, unless carefully worked through with mutual understanding, can lead to considerable tension between a mental health department and a college administration. Fortunately these instances have involved younger psychiatrists in services where supervision was available so that the problem would become worked out without serious damage. It is clear, however, that psychiatrists working in a community clinic must recognize the limits set by the community's tolerance and work within that framework. If great care is taken to avoid unrealistic special pleading a college administration will be found to be amazingly flexible within the limits of the educational system.

It is difficult to be precise about the qualities which are desirable in a psychiatrist who is to establish a college mental hygiene service. A basic requirement is competence in the field of psychiatry. Adequate training, experience and recognition such as that provided by board certification in the United States are necessary not only for theoretical reasons but also from the practical standpoint. There are few circumstances in which a physician is required to take on more pressing responsibility. He must answer to the university for his actions as well as to the parents of students, still minors, who come under his care. Consequently it is imperative that he have such qualifications as to insure his capacity to support his decisions. This is of course particularly true when something goes wrong with one of his cases, which is inevitable in any medical practice.

There are a number of special considerations bearing on psychiatric work on the campus which no amount of ordinary psychiatric training would prepare one for. Consequently it is desirable for the college psychiatrist to have had training experience in the college setting when this is possible. This is becoming increasingly feasible in the United States where such institutions as Harvard, MIT, the University of California and Yale are offering specific training in the field. At the very least it would appear that a college psychiatrist should be a person with special interest in people of college age. This is a more specific interest than might appear at first sight, since the characteristics of people in this developmental period are quite distinct from those of other periods of life. To state this position briefly, the ego of the college student is in the position of the rider of a powerful steed, released for the first time from the guiding hand of parental supervision and relatively unsure of where he wants it to go. This makes for a situation of great flexibility which lends intrinsic interest to work with college students, but it also adds greatly to the therapist's need to be sensitively aware of many internal and external

factors influencing the dynamic balance. Such awareness seems to accompany the presence of that empathic capacity which is the basis for special interest in college students.

In choosing a college psychiatrist, too, the personality of the psychiatrist himself should come in for consideration. In the intimacy of university life there is no possibility of hiding for long behind a mask of professional anonymity. The psychiatrist on the campus is a specialist among specialists and finds soon that he has no particularly privileged status. Consequently if he is to be comfortable it is helpful if he possesses a lack of dogmatism and tolerance for diverse views as well as reasonably developed intellectual interests which will enable him to feel at home outside the clinic as well as in it.

Once the psychiatrist has been selected it is up to him, together with university officials, to decide on the extent of services. Since the college psychiatrist will be involved in several fields of action it is necessary to plan his time so that it is not all taken by clinical services. His additional main functions of research and community psychiatric work must be budgeted for in time. The central contribution of clinical work with students should then be defined in terms of the limitations of the setting.

It is generally agreed that effective clinical work in the college setting depends on maintaining a policy of open intake; that is, arranging so that each student who applies for services will be seen within a relatively short period of time, if only for evaluation. It is important for the college psychiatrist to avoid over-committing his clinical time so that the open intake policy is interfered with.

There are three practical levels of clinical activity found in college psychiatric clinics in the United States. The first is exemplified in the policy of offering consultation services only. In this arrangement, students are seen for a maximum of two or three interviews for the purpose of evaluating the presenting situation and referring the case to other resources or advising the student as to his best course of action in dealing with his problem. Experience in settings like this suggest that for many college students a considerable amount of psychotherapy does take place, perhaps largely because of the inherent reassuring value of the evaluation process. In settings like this I would estimate that approximately 10% of the students who are seen—or something around 1% of the total student population—will present emotional problems of such magnitude as to require referral for more extended psychotherapy.

The second level of function is found in clinics which offer brief psychotherapy. In these settings students are seen for a 1-hour interview once a week. The average presenting problem can apparently be reasonably resolved in 6 to 8 treatment hours. Experience in such settings has been that approximately 30% of the applicants for services need be seen for only one or two evaluation interviews, while perhaps 20% require extended treatment periods of more than 15 hours. In clinics offering brief psychotherapy there is usually no attempt to treat the deep-lying neuroses or character disorders, and the aim with such cases is a preparation for intensive psychotherapy in other facilities and help with the practical details of obtaining such treatment.

The third possible level of clinic function would be one governed by the policy of offering complete and adequate treatment for every student consulting the college mental hygiene service. So far as I know, such service has never been offered on a college campus because of the dispropor-

tionate amount of effort required by the relatively small number of cases which would require quite extended treatment. However, this arrangement is approached in clinics located in psychiatric centers where it is possible to make special referral arrangements (for example, for supervised analyses) for low-cost treatment of such cases.

It is quite impossible to describe here all of the possible various arrangements which would be appropriate to specific college and university settings. Each clinic has to be organized in terms of its particular situation, making use of whatever assets and supports can be found in a given community. By way of generalization, however, it is essential that the college psychiatrist have adequate technical supporting staff. A properly chosen receptionist and clerical assistants can soon relieve the psychiatrist of many burdens of minor administration, supervision of records and the like. It is also valuable to consider the usefulness of ancillary professional assistance. The well-trained psychiatric social worker and clinical psychologist can add immensely to the range of activities in a college mental hygiene clinic, and it should not be overlooked that the services of these team members are usually somewhat less expensive than those of additional psychiatric help.

One deceptively attractive idea would be the operation of a college mental hygiene clinic as a function of the department of psychiatry in places where medical schools are a part of universities. This plan has been tried in a number of settings in the United States and for one reason or another has never been successful over any long period of time, so far as I know. Evidently the demands of the college mental hygiene clinic are such that it does not operate successfully as a secondary function or something that can be done "on the side." Consequently it is important that the college clinic have autonomy from medical school services although it may enjoy rich interchange with departments of psychiatry.

Financing of a college mental hygiene clinic. In order that a college mental hygiene clinic can function successfully it is important that it be assured of realistic financing. While it is certainly true, as pointed out by Farnsworth, that the college psychiatrist must seek part of his reward from the gratifications of university life, repeated experiences have shown that successful permanent arrangements are unlikely if the psychiatrist works at too great a sacrifice or if he is harried by an uncertain budget. It seems wiser to have a small and perhaps limited service with a firmly assured, adequate budget than to have to cut corners to expand the service. The limitations imposed by the usual university salary structure also make it desirable that the college psychiatrist be allowed limited private practice privilege.

The sources of the mental hygiene clinic budget depend upon the university's source of income and budgetary policies. In the United States the mental hygiene clinic budget is usually a subsidiary portion of the health service budget. This in turn is usually supported by obligatory fees to students, with additions from the general funds of the university. However, an increasing number of mental hygiene clinics are becoming the recipients of endowed funds earmarked for that purpose. Such services are indeed attractive objects for endowment since the services are direct and the effects quite tangible.

One means of establishing an adequate financial arrangement is by receiving grants over a limited period of time, usually three to five years. At the end of such a period, if a mental hygiene clinic has demonstrated

its value to the university, there is a good basis for continued support. While most university administrations require advice and experience with the costs of mental health programs it has been surprising to note that the respect for the program is generally greater where truly adequate support has been insisted on.

The question of being partially self-supporting by charging fees for treatment to students is one which arouses controversy when it is discussed. A frequent arrangement is that the student is not charged for evaluative interviews, but if definitive psychotherapy is taken up he is charged a modest fee depending on his ability to pay. However, under no circumstances has a student mental hygiene clinic been entirely self-supporting.

STUDENT MENTAL HYGIENE AT YALE

While it is impossible to describe all the possible varieties of clinic organization it may serve some purpose to present an abbreviated description of the division of student mental hygiene at Yale as a kind of model specimen. While this clinic is unique in many respects it is the oldest continuously operating student mental hygiene clinic of its kind, having been started in 1925 at the instigation of the then president, James Rowland Angell, who called Dr. Arthur Ruggles as his consultant in developing the service.

Organization. The division of student mental hygiene is a division of the department of university health which is responsible to a board of university health appointed by the president. The division's budget is derived from the income of a grant of $2,000,000 given by the Old Dominion Foundation, a philanthropic organization founded by the Mellon family, from funds allotted by the department of university health and derived from student fees, and from smaller grants occasionally obtained for specific research purposes.

The psychiatrist-in-chief is responsible for the direction of the mental hygiene division and reports to the director of university health. There is no direct administrative connection with the Yale Medical School but several of the members of the division enjoy appointments in that department. At least two residents a year from the department of psychiatry undertake part-time training in the division, while students who require hospitalization are cared for in the Yale Psychiatric Institute, which is administered by the department of psychiatry.

Personnel. The chief psychiatrist devotes half of his time to treating student patients and the rest of his time to administration, community activities and research. He is an active member of several university committees and consults widely with other groups. Two senior psychiatrists spend half-time in seeing student patients and the remainder of their time in research and private practice. Two psychiatrists who have completed their residency training spend two-thirds of their time seeing student patients and the remainder in supervision and conferences. Two residents from the department of psychiatry spend a day a week doing supervised psychotherapy.

Three full-time psychiatric social workers do initial interviewing with each new student patient and in consultation with a psychiatrist determine assignments. They also carry approximately 10 hours a week of casework psychotherapy with selected patients, mainly those who present problems of orientation to university life.

A full-time clinical psychologist divides

his work between diagnostic testing, supervised psychotherapy and clinical psychological research. Two research psychologists carry major long-term projects in problems of the relation of psychologic factors to academic and other kinds of achievement, while one of them sees student patients about a quarter of his time. Even the research sociologist spends a few hours a week in relationship therapy with carefully selected patients. The rest of his effort is devoted to studies of sociologic factors affecting mental health and personal satisfaction with college experience.

A series of visiting psychiatrists have stimulated the staff by discussing various theories and college settings. Senior consulting psychiatrists assist in conferences, supervision of treatment and the handling of special problems.

Activities. The central activity of the Yale Division of Mental Hygiene is in the clinical work of evalaution and therapy of college students and, to a minor degree, faculty. You may have noticed that every member of the professional staff, no matter what his primary orientation is, carries some cases in therapy with considerable opportunity for supervision. During the last year 515 patients were seen for an average of 8 hours. Studies of our case load show that something over 15% of any class graduating from the college will have consulted the mental hygiene division. Around 10 cases a year are hospitalized through the division; about 20 cases spend some time in the infirmary while working out acute problems; and 30 to 40 cases interrupt their education for some period of time because of emotional problems. The main treatment orientation is toward dynamic psychotherapy, with an occasional case being carried through long periods of time in supportive psychotherapy. It is our belief that with freely available consultation we tend to see emotional disturbances in their early stages when they are still unstructured and capable of resolution in brief periods. It seems increasingly apparent that psychotherapy of the crises of college students calls for many technical deviations from psychotherapeutic models for adults, and we feel increasingly the necessity to develop systematic descriptions of these problems. Research activity in the division is multidisciplinary and multidimensional and is aimed at achieving the broadest possible understanding of the college student and college life. In addition to those members of the staff whose appointments are primarily to research positions nearly every member of the group carries on some research activity into clinical or practical problems. We make our research findings freely available to administrative and faculty committees in the belief that the broadest possible insights into the position of the college student are helpful in determining educational policy and direction.

The community activities carried on by the division are almost too varied and numerous to discuss. However, it is the policy of members of the clinic to be freely available for consultation with the faculty and administration on problems which come up, whether they involve specific student situations, policy or referrals for evaluation. Specifically, we are consulted concerning misbehavior leading to disciplinary action, for assistance in the training of counselors and for the evaluation of students seeking admission in whom there is evidence of some psychological problem. When we discuss a specific student case it is only with his permission and always within the bounds of the confidential relationship. We also meet with various committees of the college or with special committees set up to deal with specific problems. Ideally, we wish to be

recognized as a resource to which any member of the college community may turn for help in discussing any issue involving emotional life.

The training activities involve offering supervised experience in psychotherapy to psychiatric residents. We are now evolving a 2-year program of training to begin with the third year of residency for those with specific interest in college mental hygiene work.

This thumbnail sketch of the Yale Division of Mental Hygiene may give some suggestion of the range of activity of a well-established department. Despite the relatively large size of the department, as such clinics go, the expense of the division is reasonable, being well less than half as costly as the other function of the health department and certainly less expensive than many small departments of instruction in the university. The increasing contributions of this small division to general university life is satisfying on many sides. Its members, at least, are greatly rewarded in their work.

ALINE B. AUERBACH

Varieties of purposes and methods in film discussion meetings

Many of the films shown in educational programs deal with concepts of interpersonal and community relations that are closely related to the background and goals of social work in its broadest sense. In community after community, social workers are called on to serve as discussion leaders, along with physicians, psychiatrists, public health personnel, psychologists and educators. It is therefore perhaps fitting that we look a little more closely into the matter of film discussions and raise some questions regarding their purposes, the methods one may use to achieve these purposes and what one may realistically hope to achieve through such programs.

Mrs. Auerbach is director of parent group education for the Child Study Association of America. She presented this paper May 21, 1956 in St. Louis at the 83rd annual forum of the National Conference of Social Work.

It is rare today to find films in the fields of mental health and family and human relations shown without some provision for a discussion period to follow. Many of these films are distributed, as we all know, with the suggestion that such a plan be adopted. Discussion outlines to guide the discussion leader are coming more and more to be the rule.

The trend toward providing audiences with an opportunity to talk about the films they have seen seems to stem from a number of quite different sources. In some situations, producing groups were interested in audience response, in testing out the effectiveness of the medium in conveying a specific idea. In other situations, and again for many different reasons, it was felt that the content of the film had to be "safeguarded." It was recognized that different people in a group take different and sometimes quite contradictory ideas from the

same film material—as they do from books or lectures or other formal presentations—and that comparing their interpretation with that of others may serve as a healthy check or balance. It was also recognized both by producing and distributing groups and by program planners in many communities that the material presented in a film on such complex matters as mental health and personality development, for example, had to be condensed and simplified to fit the medium. The limited amount of time available for the development of the dramatic material alone made this necessary. It was felt then that this material can profit by having members of the audience add something of their own experiences and reactions. In this way the basis of learning of the group as a whole is enriched and each individual is presented with a variety of additional facts and interpretations to which he responds in his own way as he tries to fit the ideas set forth in the film to his own life situations.

In discussing the film as a device for public health education, Dr. Paul V. Lemkau adds another reason for the use of discussion. "To a large extent," he points out, "it was found that the audience was likely to leave tense, anxious and guilt-laden unless discussion was encouraged. In such discussions it becomes possible for the members of the audience to recognize that they are not alone in these feelings, that others also feel anxious because they were not in the past able to achieve the satisfactory attitudes usually portrayed at the end of films. Discussion usually brings out technical faults in the film itself, so that it is robbed of any magical authority that may have been imagined for it. It can be discussed as something having no more authority than any other human statement. Then its teachings can be discussed realistically and the members of the audience can leave with the concept of a desirable adaptation to some problem or problems, but not feeling that, having failed to make exactly the adaptation depicted, they have in that measure failed in their own lives and in guiding the development of their children." [1]

But behind these different reasons for the stress on group discussions there seems often to be a more general, less clearly defined concept, the idea that group discussion has a persuasive, almost magical quality. How often today do we hear people say that one must just get people together to talk—or to "talk it over" or to "talk it out"—and all will be well?

This emphasis is not accidental, of course. It comes as a result of new and original research in psychology, education and the social sciences, on theories of learning, individually and in groups; varieties of diverse group experiences such as the "small groups" in the field of the social sciences, the various approaches of "group dynamics," group education in parent education and public health, and the different types of therapeutic groups in the field of group therapy. People in all the "helping" professions are becoming more and more aware of group processes as a potential means of individual growth and change and are eager to try to use them.

The difficulty that arises, however, is that here as in many newly developed and rapidly growing fields the techniques of group discussion leadership cannot be quickly or easily gained. And our skills in knowing *what* to do can only become part of us if we take the time to think through *why* we do what we do and *toward what ends.* Then the *what* and the *how* begin to have meaning.

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[1] Paul V. Lemkau, *Mental Hygiene in Public Health,* 2nd ed., New York, McGraw-Hill Book Co., 1955, 67.

It is not enough then to recognize that discussion offers a new dimension to the learning opened up by the presentation of the film itself and thus adds another possibility through which to "realize the film's full potential." We need to define the process more exactly, if we can, in order to use it effectively.

As a first step, a quick look at some of the purposes of the films themselves may give us a basis for considering the purposes toward which the film discussions may be directed.

Actually, discussion leaders themselves are often confused as to the purposes of the films; they are also often confused and dazzled by the many possible uses of the films within an agency or community program and find it difficult to settle on one or another. And the discussion guides are often not too clear either. Many emphases are valid and helpful in relation to different program goals, and by their very nature films in the fields of mental health—of interpersonal, human and community relations—fortunately lend themselves to many different uses. It is essential for the leader to see the goals clearly himself and to know the intent of those who set up the program, so that he can function accordingly. It is just as important for the leader to know the content of the film and also something about the makeup of the audience and its experience with and response to other group education and film meetings.

As these films are used in community programs of different kinds, the intent is usually educational in its broadest sense. It is hoped that the audience will take from each of the films some message or interpretation that has meaning in their personal or community life. The audience does not come together in these settings to discuss the techniques of production, as they would in a workshop on film-making, but rather to respond to and to gain something from the material it presents. If a leader sees this issue clearly he will then be able to help a group move away from considerations of whether it is a *good* or a *bad* film to the content itself (even though in talking about these matters the group will inevitably voice some reaction to the skill and realism with which they are presented).

Even within an educational program there are—and should be—many different goals for the films and the discussion that follows. It seems that three main goals predominate, although the categories often overlap. First, there are films (and programs) directed primarily toward social action in such areas as slum clearance and housing or intergroup relations or toward community support of agency programs such as delinquency prevention or medical education.

Second, there are those directed frankly to the dissemination of specific information. These may deal with health problems such as nutrition or immunization, or with child development and characteristic behavior at different stages of growth as in "He Acts His Age" [2] and the series of films that deal with particular age periods under the general heading of "Ages and Stages" [2] and "Meeting Emotional Needs in Childhood: The Groundwork of Democracy." [3] They may emphasize the prevalence of mental illness and the existence and role of treatment services as in "The Lonely Night" [4] and "To Serve The Mind," [2] or they may describe types of community services as "Angry Boy" [4] acquaints the public with the services

[2] Produced by National Film Board of Canada.

[3] Produced by the department of child study of Vassar College.

[4] Produced by Mental Health Film Board.

of a child guidance clinic and "A Family Affair" [4] depicts the functioning of a family agency.

Third, there are films (and programs) geared hopefully toward what is known as "preventive mental health." This usually means working toward a richer understanding that may bring with it a shift in attitude and may help the viewer function more effectively in his interpersonal relations. "Angry Boy" and "A Family Affair" have, of course, also been widely used toward these ends, as have the other films in the category of child development mentioned above.

One might parallel these three categories of the purposes of films with three somewhat different goals of group discussion:

1. To help a group come to a common agreement and group decision. This is often an aim of discussions that involve social action, but is a controversial point in other types of programs which are directed toward the members' increased knowledge and growth. The latter are based on an individual's right to make choices that he finds suitable, even if they go contrary to those of the other members.

2. To help a group assimilate new, specific ideas.

3. To gain a wider understanding of facts and feelings that seem pertinent in the life of the audience or group member.

These last two goals relate closely to the last two program goals above, namely, the gaining of information and the opportunity for personal growth through education, and apply to both. If one looks closer, however, one sees that they carry quite different implications and that the leader may have to make a choice of two directions in which the discussion shall go. Shall he use his leadership to confine the discussion to the material or points raised by the film? Or shall he allow or even encourage the group to use the film presentation as a springboard for their own ideas and concerns, sparked by the film but not necessarily limited by its content?

Confining the discussion to the points raised by the film can provide a thoughtful exploration of certain specific topics if these are logically developed and if the members' contributions are skillfully pulled together. If the subjects are of true concern to the group the discussion can be meaningful; if they are not, the discussion may be forced and fall flat. If, on the other hand, the film presentation is used more freely as a springboard for the group's own ideas and concerns, the discussion is apt to be more lively and personally rewarding. It may, however, become scattered and diffuse. This can be avoided if the leader keeps the discussion within the range of interest of the group as a whole and is able to integrate the comments and concerns of the members and to add interpretations of their contributions that—it is hoped—will increase their general understanding.

This may seem to be a large order. But it is the kind of discussion leadership that has been used quite effectively in parent groups. To relate, therefore, what we can learn from parent group education that has meaning for film discussions and at the same time to point up the differences between the two I shall draw on the experience of my agency, the Child Study Association of America.

The association's group program focuses on the experience of parents meeting together in small groups for a continuing series of 10 or more meetings to discuss their common concerns under skilled leadership. The association also has developed in recent years series of programs of training of professional personnel—social workers, specially selected educational and guid-

ance workers and public health nurses—to lead parent discussion groups.

"Good" group discussion can be defined in many ways. As it is conceived and used in these programs it develops from the needs of the members, in a broadly educational experience, directed toward a specific goal—that of helping the group members to better understand their children and themselves in order to function more effectively in their parent-child relations. Members are given the opportunity of sharing their day-by-day experiences and concerns, voicing their feelings as well as the facts about their successes and failures. Talking in this way they begin to get a feeling of where they stand in relation to others, of how they and their children are similar to and how they are different from other children and families. Through the interaction of the members of the group each gains increased strength from the support of the others and also from the ability to stand up against criticism. They become better able to look at a situation in its entirety, to understand somewhat better the meaning of specific behavior. By checking their expectations and fantasies against reality within the framework of the group, they seem to gain new attitudes and new expectations for themselves.

These are some indications of what can take place in group discussion if the program is related to the needs and interests of the group, if it is suitably carried out and if the members are not emotionally blocked in their ability to learn. Group discussions such as we have described are not directed toward the pathological aspects of personality function but are educational in nature, using the word in its broadest sense to include attitudes as well as facts. It must be remembered, however, that the techniques of discussion and some of the possible results suggested here are drawn from discussion over a series of meetings during which the material is developed at the group's own pace, and time is provided to allow for the effect of the group process. We have seen too, however, that modifications can and must be made in different settings and that if aims and purposes are defined realistically similar techniques can be used appropriately.

To what extent then are these concepts and methods applicable to discussions of films?

Discussions of films may take many different forms. Sometimes the film showing is followed by a discussion by one person, usually an authority or specialist in some aspect of the fields drawn on in the film presentation. His participation depends on the way in which he sees his role. He may be called a discussion leader, yet he may feel that he can contribute best by giving his own views about the film. In this case, he serves as a discussant rather than a leader of discussion from the group.

Sometimes a panel of several participants is invited to discuss the film; they share their reactions as if they were functioning as a small group. This is often planned to open the way for discussion from the floor and may serve well to broaden the base of the discussion by introducing new material and raising questions for the group to carry further. On the other hand, the presentation by the panel cuts down the time available for comments from the audience.

Sometimes one person is clearly chosen to serve as a discussion leader. He may use any one of many group techniques. These may include buzz sessions, "discussion 66," *etc.*, which are designed to break the audience into small sub-groups so that members may participate more freely as they discuss one or several aspects of the material presented. Each of these methods has certain

advantages and limitations. For the purposes of this presentation we are focusing on those film discussions in which the leader develops the discussion from the audience, applying to this setting such group discussion techniques as are suitable.

Obviously this situation is different in several respects from the discussion that takes place in a continuous series of discussion meetings as described above. First, instead of building the discussion from the individual contributions of the group members, the group as a whole is presented with a body of specific material which they all share at once. This immediately broadens the group experience by giving a common base to which they can respond. It has the further advantage of being presented with dramatic impact, making use of all the audio-visual elements to put before the audience a significant experience rather than an abstract idea. But while this gives a broader common base it is in another sense more limiting. The content is chosen for the group, in the first place by the filmmakers and secondly by the program planners who select a particular film to present. The content may or may not be close to the needs of the group. Also, while the exposure of the group to the same film content may seem to give a common ground on which to start the discussion, members react differently to what they have seen, out of their own different lives and capacities. The discussion then must first clarify as much as possible the nature of the response to the film, to establish what it is on which the group can build.

Films are most frequently presented to groups in single meetings, of course, or if there is a series each session starts with another film presentation. There is little time to develop the material gradually from the interplay of the group members. The extent to which this is possible is further dependent on the size of the group. A large attendance (of more than 30, perhaps) will naturally limit participation in the discussion to those who are most articulate, most aggressive or often most troubled. The more reticent members never get a chance because of the limited time. Because of the size of most groups and the obvious inability to explore and adequately meet the needs of the members, discussion at such meetings can usually only be a beginning. The important point is that it *can* open up for the group new ideas and feelings which, it is hoped, they will think about more fully later either by themselves or in other groups.

How much can be realized depends to a great extent on the leader. How well has he thought through the possible gains and limitations of the discussion and his own role in it? On what background of knowledge and skills can he draw? Leadership—whether of discussion in a continuous series or in film-meetings—requires knowledge of content and skills.[5] To lead discussions of interpersonal and human relations it seems essential that the leader have a wide knowledge of personality development and the dynamics of behavior. He should use this not to pour information out to the group but rather to know where to encourage the group to look at other aspects that will broaden the picture. He must be able to generalize from the discussion with concepts that tie together and give a broad perspective to the questions and comments of the members.

He must also know what is appropriate

[5] See Aline B. Auerbach and Gertrude Goller, "The Contributions of the Professionally Trained Leader of Parent Discussion Groups," *Marriage and Family Living*, 15 (August 1953), and Gertrude Goller, "The Place of Psychodynamic Orientation of Professional Leaders in Parent Education," *Journal of Psychiatric Social Work*, 24 (September 1955).

for group discussion and what is not, differentiating the more normal from the pathological. How a leader can handle pathology as it is revealed in the group would be a subject for exploration by itself. Perhaps we need only suggest here that it be done in a way that is not threatening either to the individual or the group—by accepting the validity of anything that is expressed but indicating that some ideas can more suitably be explored in a group than others and by being ready to suggest other sources of help if this seems indicated and a favorable opening is provided. These, of course, are situations with which the social worker is familiar and usually expert in the person-to-person relationship. Some of the same considerations apply in the group with the added factor, however, that here one is faced with multiple responses to the leader's handling of one individual.

In our experience, social workers by and large are not so familiar with the techniques of group education or, as it is called in some settings, group counseling—techniques which we are discussing here as they have bearing on film discussion meetings. Another paper might be devoted to this topic too—on the *how* that helps the group toward its goals. In a paper on basic concepts in the technique of parent group education,[6] Dr. Peter B. Neubauer has formulated some principles of group education as applied to parent groups that are relevant to any group discussion. He points out that although these skills take time to learn they can be acquired by a thoughtful and conscious use of one's professional self toward specific goals.

The leader, then, should adapt his discussion techniques realistically to what the setting can be expected to provide—even within one discussion period. He can direct the group toward one of the goals we have already mentioned, sharing their different reactions to the theme of the film if that is his choice or voicing their common and different concerns about aspects of their lives suggested by the film-content if he sets the course of the discussion in this direction. In either case he can help the group (although to a limited degree, to be sure) to see what group discussion can or cannot be expected to achieve. It may not be easy for them to accept the fact, for example, that as group leader he is there not to answer their questions but to encourage them to work out their own solutions on the basis of better understanding. But a start can be made in this direction. The leader can strengthen this point by relating specific questions or comments of one member to the experiences and ideas of the group as a whole. In this way the member with a "problem" and the others in the group will be helped to see, perhaps, that such discussion meetings are not problem-clinics, that "problems" (and many general questions too) need more exploration before anyone can begin to work out for himself new solutions or modified attitudes. Here too, however, even such a point is often a gain not to be underestimated.

More fundamentally, then, what can and should emerge from discussions around mental health education films is a point of view as a beginning of learning. This point of view could be described in many different ways. I would hope it might include some of these ideas:

1. That certain concerns of people about themselves and their families are universal, yet that individuals differ considerably in their response to similar life problems.

[6] Peter B. Neubauer, *The Technique of Parent Group Education: Some Basic Concepts* in *Parent Group Education* and *Leadership Training*, rev. ed., New York, Child Study Association of America, 1953.

2. That human development is marked by characteristic development stages, each with specific tasks.

3. That the response of individuals to these tasks takes different forms, depending on the individuals, their families and the culture in which they live.

4. That most "problems" of life adjustment are not met with easy or quick answers, since they are complex in nature and need to be looked at in their complexity.

5. That reasonably healthy people, unless they are blocked in their learning by areas of emotional conflict, *can* acquire insight and knowledge, even though slowly, through educational experiences and in groups, and that better understanding of a whole situation makes it more possible for them to face and deal with it effectively.

These formulations may seem obvious but we sometimes lose sight of them in the excitement and stimulation of a group in which as leaders we may be trying zealously to meet the needs of each person who speaks. They may help to give us a focus within which we can balance the needs of the individual with those of the others in the group. Thus we can use our skills to help group members together to gain through their own strengths as they react to what the film has given them and move toward "realizing the film's full potential."

ROBERT GIBSON, M.D., D.P.M.

Incidence and pattern of crime among mental defectives

Although a diagnosis of mental defect in a delinquent is not in itself an explanation of delinquency, the defective's failure to achieve happiness in ordinary ways may lead to the adoption of delinquent conduct as a compensatory mechanism, more especially where upbringing has been lax. The defective may commit a criminal act simply because he does not realize what he is doing. It is equally commonplace knowledge that at other times he may know what he is doing but fail to realize it is wrong, or if he does he still may not appreciate how wrong it is. Finally, he may know what he is doing and also appreciate how wrong it is but yet fail to keep from committing such an act because of defective control.

The extent to which defectives are involved in criminal proceedings has been the subject of study by various investigators. Dealing with delinquents who were mentally defective, East (1927) quoted the figures obtained from the examination of 1,462 male adult prisoners received into Brixton Prison, England, on whom the courts had called for psychological reports. Each of the accused was examined by two or more experts, and the consensus was that 1.3% were certifiable as mental defectives, 1.4% were not certifiable but showed abnormal conditions, and a further 1.5% were insane. Where male adolescent prisoners were concerned the same authority cited the results of examination of 1,730 lads aged between 16 and 21 years who had been received over a period into the Boy's Prison at Brixton. He found that 38, or 2.2%, were certifiable as mental defectives and that 54, or 3.1%, were border-line mental defectives. Further investigation of 4,000 male adolescent delinquents in the London area, car-

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ried out by East, Stocks and Young (1942), revealed that nearly 4% were mentally defective. The incidence was put somewhat higher by Burt (1955), who estimated that just under 8% of juvenile delinquents were mentally defective whereas 28% were definitely dull and no fewer than four out of every five delinquents were below the middle line of average ability.

In studying the causes of delinquency Burt drew attention to the multiplicity of factors which were apt to be involved, apart from low intelligence. In this constellation of factors, however, low intelligence plays no mean role and its importance was underlined by Ferguson (1952), who claimed that delinquency increased as scholastic ability decreased. Ferguson's survey was based on over 2,000 Glasgow boys, including ordinary school-leavers as well as those physically and mentally handicapped. The mentally handicapped group consisted of 301 boys, both dullards and defectives, born between the middle of 1931 and the middle of 1933, who left special schools in Glasgow at the age of 16 years. It was found that nearly 24% of the mentally handicapped between the ages of 8 and 18 were convicted, with an average number of convictions of 2.0 per convicted boy. This compared unfavorably with the records of physically handicapped and ordinary school-leavers. Rather less than 11% of the physically handicapped were convicted, with an average number of convictions of 1.9 per convicted boy, and just over 12% of ordinary school-leavers with an average number of convictions of 1.6 per boy convicted. From the results of his survey as a whole Ferguson concluded that a low level of scholastic ability was probably the major factor associated with a high incidence of crime. At the same time it would be wrong to underestimate the importance of environment in the causation of delinquency in mental defectives. This aspect was taken up by Davies (1930), who pointed out that the impressionable and easily influenced nature of defectives enabled them to reflect their environment and that therefore a high incidence of delinquency amongst the defectives in a community would provide an index of social conditions and underline in turn the need to seek a cause in the community itself.

In defectives the pattern of crime presents certain features of interest apparent not only in the antecedents of the crime but also in its type and in the method by which it is carried out.

A study of the circumstances leading up to the delinquent act naturally takes account of apparent temptation, provocation and motives. The moral qualities required to resist temptation are in general less strongly developed; lack of foresight and judgment coupled with heightened suggestibility tends to lower resistance, and impaired control further contributes to the committing of wrong acts. For similar reasons less provocation may be necessary, the fleeting opportunity creating the stimulus and defect of control leading to theft, firing of haystacks or more serious delinquency. In other cases there may be no clear provocation and delinquent conduct appears to arise quite impulsively. Whilst in many instances it is possible to establish a motive, whether it be obvious as in cupidity or less obvious as in sadism, the seemingly unmotivated character of some acts may serve to indicate the need of further examination for epilepsy, psychopathy or psychosis.

Although no crime is restricted to mental defectives certain types are more frequently related both to mental deficiency itself and to the degree of defect. East considered the commonest offenses to be those of acquisition, such as stealing, embezzlement and false pretenses, and then sex and va-

grancy. From an analysis of the intelligence levels of 197 male defectives the same writer showed that theft and indecent or criminal assault on women and children were associated with a higher level than wandering or common assault. The respective mental ages were 8.7 years for theft and 8.4 years for indecent or criminal assault on women and children, compared with only 7.5 years for common assault and vagrancy.

When the frequency of crimes committed by defectives is considered in relation to the total volume of crime a significant picture emerges. Of the total volume of indictable crimes in England Milner (1949) pointed out that about 90% were acquisitive, about 3% offenses of violence against the person and about 3% sexual offenses. When, however, the contribution of defectives was analyzed Milner found that acquisitive crimes, although frequent, were usually trivial, crimes of violence were fully twice as frequent as in the ordinary criminal, but sex offenses were nearly 10 times as frequent.

This incidence of sex offenses agrees closely with the findings recorded in Scotland by Ferguson (1952), who showed that 0.4% of ordinary school-leavers were guilty of sex offenses whereas no less than 4.7% of mentally handicapped boys were charged with sex crimes. The sexual offenses recorded by Milner included the more serious charges of criminal assault on women and children and attempted rape as well as indecent assault on males or females, indecent exposure and bestiality. It is noteworthy that children are more likely to be the victims of criminal assault or attempted rape. Defectives—with their adult sex impulses but the mental level of children—would appear to direct their instinctive drive towards those on their own intellectual level and hence they constitute a particular menace to children. Of lesser sex crimes indecent exposure is frequently associated with mental defect, and bestiality occurs predominantly in either mental defect or dementia. Crimes of violence by defectives range from murder to cruelty to children and torturing of animals.

The method of carrying out a crime may itself shed light on the mental state. Most commonly it reveals a defect in design, a failure to take elementary precautions and insufficient foresight to benefit from the offense. Not only may great risk be run for trifling gain but the proceeds may even be thrown away. Generally the history of such individuals provides abundant evidence of a lack of prudence and foresight. In other instances the matter may be complicated by an element of psychopathy or psychosis. Defectives who are also psychopathic are apt to show additional features of wantonness, senseless cruelty and motiveless lying. When psychosis is engrafted on mental defect the crimes perpetrated in this state may present bizarre features. East (1927) instanced a case where a defective with depression murdered his infant by first bludgeoning it, then burning it on the fire and finally placing it head downwards in a pail of water. According to this author, psychosis should be suspected where several efficient methods of killing, any one of which would have effected its purpose, are adopted in succession. The presence of psychosis is especially important in murder charges, where insanity may be a legal excuse whilst mental defect is not unless it involves unfitness to plead, failure to recognize the nature and quality of the act or failure to realize that the act is wrong.

This raises the further issue of legal insanity. Only a proportion of higher-grade defectives can be considered fit to plead; the others, as well as all imbeciles and idiots, are in the same position as psychotics who

are unable to fulfill these conditions and are therefore deemed insane under the law. Accordingly, a defective found unfit to plead may be detained as insane under the law even if no actual psychosis was detectable on examination.

If on the other hand he is found fit to plead, the question of criminal responsibility becomes primarily a legal issue. It is then for the court to consider the facts of the case, review the medical evidence of mental defect which might influence conduct, and decide whether such mental defect has so influenced conduct to modify or nullify the criminal responsibility of the accused. It may be established that through defect of reason the accused was unaware of the physical consequences of his actions or did not know that they were contrary to and punishable by law. However, even when a defective is found guilty of a criminal act, proved mental defect may still operate as a bar to punitive sentence. Under such acts as, for example, the Criminal Justice Acts in the United Kingdom (England and Wales 1948, Scotland 1949) it is the duty of the prosecutor to arrange for the mental examination of a presumed defective and to lay evidence of deficiency before the court. The court may thereupon order removal to a mental deficiency institution, the institution designated in the order being compelled to grant admission. For a first offender, however, whose conduct has hitherto been above reproach, whose offense is trivial and who has been subject to considerable temptation the case may be met by guardianship, accompanied perhaps by attendance at a clinic to insure continued observation and after-care. For more serious cases committal to institutions is the rule. Some are committed to ordinary mental deficiency institutions but others of vicious and dangerous propensities, such as those guilty of serious sex offenses, violent assault or burglary with violence, may be sent forthwith to the special state institutions set up for defectives of this type. Finally, admission may be to a mental hospital in a small minority of cases where delinquency appears related more to psychosis than to mental defect.

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HENRY S. MAAS, PH.D.

Culture and psychopathology

The social worker in our society deals daily with persons in stressful situations. His ultimate goal is to help his clients live the most personally satisfying and socially productive lives they can. To do so, they must be assisted in their times of crisis in ways which help them maintain or regain their mental health. The criteria for assessing mental health are elusive, but here are three standards which seem adequate for this discussion.

We are mentally healthy, first, when we have a pretty firm hold on reality—that is, we perceive the world around us as well as ourselves with a minimum of self-defending distortions; second, when our capacities for feeling and thinking are not too often blocked by inner unconscious protective operations—that is, most of the time we engage in living creatively and responsively; and, third, when we adapt or adjust to most unusual or unexpected and therefore potentially stressful situations without serious damage to our bodies, our psyches or others in the world around us. Note that all these criteria are stated in the relative and slippery terms of degrees—"minimum," "not too often," "most of the time," *etc.* There are no clear-cut demarcations of mental illness; no clean bills of health may be issued to anyone for all times. In regard to the third criterion, adaptability and adjustability in the face of the unusual or unexpected, we must remember that certain crises none of us can endure, and each of us has his own private Waterloos beyond which becoming mentally ill is the only route to biological survival.

Those who lose their hold on reality in a gross way, substituting their private fantasies for sizable segments of the world around them, we generally call psychotic; for them, inner impulses are the primary guides to action and almost completely re-

Dr. Maas, associate professor in the University of California's school of social welfare, presented this paper in June 1956 in Berkeley as part of a university lecture series on problems in the social services.

place responses to the goals, means and controls of the surrounding culture. Others whose thinking and feelings may be blocked to a lesser degree but whose creativity and responsiveness are dulled by excessive inner listening to the voice of conscience (or the learned demands of the culture) are considered neurotic. If psychotics have fled their culture, neurotics are the prisoners of their culture. Neither mode of adaptation to stressful situations can lead to a personally satisfying and socially productive life.

Finally, at least for present purposes, there are those who more or less consciously find society's expectations for approved behavior unacceptable; they see themselves as exceptions to the rules of the group and while they often accept for themselves the goals of the culture—for example, in ours, acquiring as much money as possible—they rarely live as though they understand the need to achieve these goals by culturally acceptable means and thus may con, steal or even kill for it. They are among those we say have a character or personality disorder. Defects in the development of personality arise in the course of growing up as one fails to incorporate or actively rejects some but not all the important standards of one's culture. Our hunch is that here the developmental process of identification with parents and/or their substitutes goes awry.

This much, by way of introduction, to reviewing what we mean by psychopathology and hinting at its relationships to culture. (We are obviously not giving any special attention to organically based forms of psychopathology.) And by the term *culture* we mean simply the characteristic or customary ways of living of a group of people, including the beliefs, values and attitudes which direct their habitual behavior. If all the above seems painfully oversimplified, I ask your forgiveness. An introductory statement must be kept from qualifying and ramifying itself into a full-length presentation.

With preliminaries out of the way, the body of this discussion opens with real-life material as a basis for more general observations. All these observations have to do with relationships between the social worlds or group life of people, on the one hand, and with the mental health of the individual person, on the other. The real-life material concerns the mental health of one man, and culture is considered in its broadest sense, as the ways of life of a sizable group of people in a sizable, fairly well defined region of our country. If some of the observations made about this one man and his culture seem far too broad on the basis of the limited data presented, my only excuse is limits of time. With more time, we could easily have more data. If the final set of generalizations, moreover, fails to make us happy, they should at least stimulate us to think—and this is after all the first obligation of a university to its students.

Not so very long ago I met Pvt. Edward Jones.[1] We were both in the U. S. Army. Private Jones had been assigned to pole line construction. I had been assigned as a social case worker in an army general hospital.

Private Jones was a tall, lean, 23-year-old Negro from the deep South—rural Mississippi, as I recall. He had been sent to the psychiatric ward because of his odd behavior. Our questions were: Is Private Jones mentally ill? If so, in what way is he mentally ill? What then is appropriate treatment for him?

When I first met Private Jones he seemed

[1] This, of course, is a pseudonym.

moderately relaxed. He spoke with me quite openly about his situation, though he rarely looked at me as he spoke, and then only furtively. His speech was soft and southern.

He explains that this is the fourth time he has been in an army hospital since his induction 13 months ago. Simply, he explains that when he gets the command to "speak the word of God" and does not do so, God gives him spells. When he does obey the word he gets in trouble with the army. He has been ordered not to preach while on duty. He has been moved from outfit to outfit. The "orders to preach" have come upon him repeatedly when he has been on a weapons range. When he denies these orders he falls to the ground "speaking tongues." These episodes last 30 minutes to an hour. The last one occurred last Wednesday.

Private Jones's adjustment in the army has thus not been a good one. The conflict is clearly one between heeding the Holy Spirit and following army rules and commands. One time while he was on kitchen police (KP) the spirit moved him and he went to church and prayed for hours—for which he was court-martialed. He feels that nobody in the army understands him or the work he has to do.

Prior to entering the army, Private Jones spent two years in the field preaching nights and working part-time during the days as a cook, waiter and insurance agent. He got along well on his jobs; he was never fired, although he would quit for periods of as long as a month to "deliver the word." Four years ago he decided to devote his life to the ministry.

Private Jones's family lives on a farm as sharecroppers. He attended school to the eighth grade, quitting because it became necessary for economic reasons for him to help out on the farm full-time. In spite of the efforts of Private Jones and his brothers, who raised good crops, the father did little but waste their money on liquor. The family always had it hard financially—worse, according to Private Jones, than most other people in the community.

Private Jones's father was a minister too, although not a good one. He would abuse the mother often, work the children like slaves, drink heavily and in general not act as a good Christian should. When Private Jones was 15 his father denied him as his son, claiming the mother had had him by another man. Private Jones said that about this time he turned more strongly than ever to the Heavenly Father.

Since entering the army, Private Jones's girl has met and married another man. He does not believe in having more than one girl at a time. Sexual relations out of marriage he believes are no sin against God, though they may be against one's own body.

He plans to continue in the field of the ministry. The army offers no future for him because of his education, although he has seen "the truth and been visited by the Holy Ghost." Private Jones does not feel he will be able to finish out his service in the army as things are now. Even a dishonorable discharge would be satisfactory, as it is "God's will" that he leave the service.

Private Jones spends his time on the ward writing lectures, waiting for an opportunity to do more preaching and curing.

Here is a man who is apparently a law-abiding and accepted person in his own community—so, at least, the Red Cross home service office worker reports to us. The physician asks about this man: Are these hallucinations he hears and sees? The social worker asks: Are these socially approved and learned behaviors, not too un-

common in his home community—or larger subculture? The psychiatrist may say: Here is a paranoid personality. The social worker may say: Here is a man with beliefs, values and attitudes shared by others in his own world, a man who has found work which is approved and even highly valued in his world. Is this mental illness? Or is this cultural training, appropriately expressed in one culture and not in another? Is this in some sense both? Or is there no mental illness here at all? These are important questions, obviously, because the treatment to be provided for Private Jones depends upon their answers.

We have suggested, in not all precisely defined terms, criteria to use or cues to look for in regard to mental health and mental illness in an individual. They have to do with the person's (1) grasp of reality, (2) ways of feeling and thinking, and (3) flexibility in adapting or adjusting under stress. Let's apply criterion 2 first, ways of feeling and thinking. Admittedly, we have very little information here, assuredly not enough to answer this question with any certainty. But what do we know about the ways Private Jones expresses (or fails to express) his feelings? What are his feelings in relation to the content of our interview? How does he communicate, in thought and feelings, with the interviewer? If I note that "he rarely looked at me as he spoke, and then only furtively," I can only wonder whether status and caste differences between a deep South rural Negro enlisted man and a white officer may not account for such behavior. If I add that he seems appropriately unhappy, in view of his total circumstances in the army and specifically in reporting that his girl had married another man, you know at least that he does not giggle at what we in our dominant core culture—the ways of white, Protestant, middle-class America—consider adverse circumstances. Nor does he weep with overwhelming and perhaps excessive grief. Nor is there evidence of anxiety in the interview, blocking his thought processes or his communication of feelings; this we might expect to find among some neurotics, beset by inner conflicts. But Private Jones seems unconflicted within; his is a battle with the outer world—with the demands of his new culture, the military—so foreign to the world he has known before. To all appearances his thinking seems organized and his feelings seem "appropriate"—that is, in our own cultural context—and we must be aware that when we term a client's expression of feelings "appropriate" it is always in some cultural context, usually our own. We should instead be using the norms of the client's own culture—that is, his realities. Clearly only his perceptions are odd, and his reactions to them: the visits from the Holy Ghost, the heard commands from God, the subsequent spells. Odd, that is, again in our cultural context.

Here then the other two criteria—grasp on reality and adaptability or adjustability to the unfamiliar—come into consideration. From the outset there is no question on the latter criterion: Private Jones is not flexibly adjustive to the Army's way of life. He is clearly no chameleon. He will not concede to the powers of the new culture that its beliefs, values and attitudes are right; to do so is to admit that his own culture's beliefs and values, in which he has invested so heavily, are wrong. He thus fails the mental health test of adjustability—as do many of the men of conviction we have known, among them many whom our neighbors have called crackpots or worse, and a very few who have emerged as true—though not necessarily good—leaders.

But what of the first criterion—grasp on reality—in regard to Private Jones? And

here we enter into more direct consideration of the concept of culture. May we start off generally?

All of us are at the same time both unique separate individuals and members of many groups. The most familiar of these groups is the family, with its roots in many past families, branching off into many other concurrent families. All have as forces in their daily living the beliefs, values and attitudes which parents have learned and passed on to their children and shared with their kin and their neighbors. The beliefs are group-shared assumptions about man and the world around him. The values are group-shared guides to what each person strives to do and be—the "shoulds" and "oughts" of a group's living. The attitudes are sets toward behavior in repeated kinds of situations, sets which are learned in the course of growing up and becoming a member of the group. These beliefs, values and attitudes are an integral part of each group's non-material culture; they underlie the group's characteristic or customary ways of living. Normally they are tied into our concepts of ourselves, and they are not easily modified—whether they are attitudes toward eating certain foods, values concerning how a mother should treat a 2-year-old or beliefs about supernatural forces.

On the birth of a child no father in our social circles is likely to take to bed, expecting rest and attention, while mother goes off about her daily chores. Yet there are groups in this world among whom the *couvade,* as this practice is called, is customary and therefore a part of the culture and therefore a reality. No hospital close by would present a just-delivered mother with her newborn trussed up tight in kinds of winding sheets, so to keep him for the first eight or nine months of his life, with only his face clear to view. Yet in present-day Russia and Poland and elsewhere the swaddling of infants is customary and therefore a part of the culture and therefore a reality. So from the very earliest days of life the newborn and his parents experience rest or activity, physical restraints or freedom and a host of multiple variant relationships with one another—varying, in part at least, with the beliefs, values, attitudes and consequently with the habitual ways of doing things which in one culture "make sense" but may well not in another. Realities vary from culture to culture.

If realities vary, then so do the norms for personality—and personality deviation. What is the model of the good man or good woman in this cultural group? What then is the bad man or woman, or child, or teenager in this cultural group? Cultural models are expectations. Cultural expectations, like personal feelings, are realities. And these vary—these models and expectations —from one subculture or region to another within these United States. In essence, this means that if what is real in one culture is unreal in another, then mental illness must always be considered against cultural norms. It means that the social worker cannot truly understand a client without understanding the customary ways of living in *his* cultural group.

What are some of the realities in the world of Private Jones? In his community, to be disowned by one's father has its painful aspects; but his is a matriarchal culture where mother is the important one, and her mother, and her mother's mother; and children are often fatherless, or step-fathered, or foster-fathered, or uncle'd; and the adult male typically leaves to the womenfolk almost all the responsibility for the rearing of children; and older sisters and aunts and cousins and friends with no blood-ties keep their doors open to displaced or errant chil-

dren—in this culture a slave-driving, alcoholic, often-absent father may be less threatening to a boy, because the system has built-in supports and facilities for the many children often in just such a spot. Cultures have their own inner balances, like the human body, or they die. Things would be different, with different meanings and feelings and inevitably different effects, for the child with a slave-driving, alcoholic, often-absent father living in the suburbs fringing Oakland or San Francisco, where families may be far-removed from blood-relatives or their substitutes, where merely an unmowed lawn may be cause for ostracism, where each child belongs squarely to the little modern house behind it. Finding no shelter there, or too much that is of a stressful nature, he is lost. Fatherless there, he is an anomaly, an unusual or odd one, and perhaps a sad one or even in time a sick one. For him to quit school at the eighth grade would be unheard of; Edward Jones, we may be sure, had many peers who did likewise. What, in the first place, is a stressful situation, and how, secondly, one reacts to stress are to some degree related to the kinds of situations and reactions one finds among others in one's culture. Social scientists have coined the term "relative deprivation" and provided evidence that the sharing of pressures by many in a group may in effect reduce the impact of the pressures upon each individual in the group.

Most important, for current purposes, in our assessment of what is culturally real for Edward Jones is the sanctioning of spiritual experiences of the types he described. The visions and other flights in which men engage, whether privately or in small or large groups, vary in form from culture to culture; in effect—or, perhaps, purpose—they are not too different. In our age of TV and cinemascope spectacles who is to say whose modes of flight are the best? Among the Balinese the trance involves the priestess and dancers at special ceremonies. Margaret Mead and Gregory Bateson observe in their study of Balinese character that in this culture "the ordinary adjustment of the individual approximates in form the sort of maladjustment which, in our cultural setting, we call schizoid." [2] But if this is a self-perpetuating and characteristic way of life, to be otherwise is to be out of touch with the realities of this culture, to think and feel unlike the others and to be unable to communicate in the appropriate symbols with one's neighbors. For example, Bateson describes how his typically warm and outgoing Western-world approach to children frightened both their mothers and the Balinese children themselves, until he learned to express his feelings in the Balinese way. Child-rearing among the Balinese, as among all peoples, has its frustrations and barriers as well as its rewards and its accommodations. Because early parental practices among the Balinese are markedly different from ours, in a larger cultural context which differs in countless other ways too from ours, these people's repeated involvements in, for example, physical proximity in crowds and at the same time their repeated experiences of "awayness" or trance-like episodes should not surprise us. The visiting anthropologist notes these behaviors as different from our own and gathers data to try to understand them. He does not call them symptoms of illness because they are odd to occidentals.

To have concluded that Private Jones needed psychiatric treatment because of his use of his culture's modes of awayness would have required an insistent belief in the reali-

[2] Gregory Bateson and Margaret Mead, *Balinese Character, A Photographic Analysis.* New York, New York Academy of Sciences, 1942, xvi.

ties of our culture as the only realities for men anywhere on the face of this globe. Can we be so sure that ours are the *only* ways and the right ones? We must be clear that culturally sanctioned behaviors may look like the symptoms of mental illness but have quite different meanings for members of groups whose culture differs from ours.

From the above and related data the following generalizations are made:

1. People's beliefs, values, attitudes and consequently their habitual behaviors are largely a product of what they have learned in their own cultural groups.

2. What is typical behavior in one group may be atypical in another.

3. What look like psychopathological adaptations in one cultural group may be proximate to or not too far removed from the norms in another culture.

4. Every culture, if it is to survive, provides both sanctions for a range of approved behaviors and taboos for a range of disapproved behaviors. Every culture develops outlets and supports for its members to express some of their drives and barriers or restraints to the expression of other drives. To this extent all cultures impose frustrations upon cultural group members; all cultures define certain situations as stressful; and perhaps therefore all cultures, from the simplest to the most complex, are known to have mental illness among their members. In other words, wherever this problem has been studied some evidence of mental illness has been found in every cultural group. Thus the search for a way of life in which mental illness is non-existent has as yet borne no fruit.

5. While it seems almost certain that no cultural group studied thus far, whether the simpler, pre-literate societies of far-away places or the highly organized communal farm societies of the Hutterites in the Dakotas and Canada, is free from mental illness, each culture seems to have a disproportionate share of at least one type or another type of mental illness. Even in the subcultures of our own country, studies repeatedly show that there is a higher incidence of neuroses in the middle classes, with their more highly organized group life, their emphases on conscience and duty and achievement, all under a burden of guilt. By contrast, there is a higher incidence of those psychoses called the schizophrenias among the lower classes, where poverty and inadequate housing, a less well organized community life and much geographical mobility among families, plus greater freedom in the direct expression of aggression are more likely to characterize the way of living. Relationships between form of psychopathology and type of culture could be spelled out in more detail; the generalization, I trust, however, is clear. Types of culture and some types of mental illness seem to be related phenomena.

To come back to cases, in Private Jones's world we expect to find more mental illness of the type some psychiatrists would say he bordered on—schizophrenia. Among members of the white Protestant family who owned the farm on which the Jones family sharecropped—especially among their children who headed for the big cities, determined to get ahead, driven and perhaps guilt-ridden though eventually financially successful—inhibition of feelings and loss of spontaneity do, at least in our times, afflict a sizable number of them and their friends. Here are a formulation and a problem to give us pause for thought and hopefully to lead us to action—when science through its empirical research provides us with the kinds of knowledge we so badly need to guide the way.

PAUL H. HOCH, M.D.

New aspects of treatment for mental illness

I am greatly honored to be invited to discuss some of the newer trends in psychiatric treatment, specifically the impact of the new drug treatments on hospital organization and hospital planning. In addition to the newer drug treatments, of course, other psychiatric treatments have also been used and will be used, and experimentation with other treatments than drug treatments is also constantly going on in the different institutions and research installations. Nevertheless, because you are reading so much about the new drugs I should like to give you a very short review of where we stand with this form of treatment today.

Before discussing the impact of this new form of treatment on the organization of our hospitals I should like to take a few minutes to outline to you where and when these drugs are used. The great medical journals like the *Reader's Digest* or the *Saturday Evening Post* and many others convey to you approximately the value of these drugs. Nevertheless, occasionally we shall have to augment or even sometimes correct some of the statements you read.

The most effective drug in our hands today is chlorpromazine, which is followed in rank by rauwolfia preparations. All other drugs that you read about are far less effective, especially in seriously sick mental patients.

These new drugs have one great advantage over other drugs which were used before. We had drugs before which sedated a patient, reduced the patient's excitement, but these other drugs—the barbiturates, for instance—inevitably, in higher doses, produced drowsiness and even sleep. The advantage of the new drugs is that we are able to sedate the patient or, as their popular

Dr. Hoch, who is commissioner of the New York State Department of Mental Hygiene, presented this paper April 5, 1956 in New York City at the First Annual Mental Health Forum of New York State.

name indicates, tranquilize the patient, without inducing sleep. The patient remains ambulatory and is also in full contact with his environment. And being more quiet, being more tranquil and not dominated by his symptoms, he is reachable and accessible to other forms of treatment which can be given in addition to the drug therapy —for instance, psychotherapy or other methods which are used to influence a patient.

Now these drugs are most effective in patients who are excited or disturbed or tense or very anxious. They are far less effective in patients who are apathetic and driveless and who are not in a state of tension or excitement.

These drugs are not specific chemical therapies for a certain disorder. For instance, a drug doesn't influence or cure schizophrenia or doesn't cure arteriosclerosis, but in some schizophrenic patients and in some arteriosclerotic patients the drug is able to quiet the patient and influence considerably the patient's symptomatology.

It has to be stated furthermore that these drugs are not responded to by every patient in the same way. The individual variations are very great and we do not know yet why one patient responds to this form of approach and others do not. Therefore they cannot be universally applied and they are not treatments of which you can expect that, say 80, 90 or 100% of all the patients treated will recover.

The new drugs are most effective with acute patients, that is, patients whose sickness is not too old. They are far less effective with chronic patients. I am sure that when we review the effectiveness of these compounds a few years from now we will be able to state that we can accomplish a great deal with these drugs with acute patients, and we can also accomplish a great deal toward changing the behavior of chronic patients; but of those patients now in the institutions who have been there for quite a number of years the actual number cured will probably not be as high as is estimated today.

In a hospital organization, to turn to this aspect of our problem, the drugs have effected a drastic change of great significance, namely, the elimination of the disturbed wards. The disturbed wards were full of patients who were noisy, disturbed, excited, destructive. In most hospitals where the drugs are used adequately and where the patients are treated with these drugs for a sufficient length of time we are able to observe that the patients in these wards are far less noisy and far less destructive. Their behavior is usually more quiet and, I would say, more mature than before.

These patients today are able to be on wards which are clean and which are furnished similarly to other wards. There are draperies at the windows and cloths on the dining-tables. The patients are able to use utensils for eating, working and recreation which were formerly forbidden because there was always a danger that they would use them against others or against themselves.

The isolation of disturbed patients, the restraint of disturbed patients, is markedly reduced. It is, of course, not fully eliminated but it is markedly reduced.

Now, if this chemical treatment of mental disorders has not accomplished anything else when we review its efficacy ten or fifteen years from now, this is such a considerable advance over former treatment of patients in the disturbed wards that I believe this alone would indicate progress in psychiatry in this area.

I should like to dwell one minute on restraint. Excited, disturbed patients have to be restrained because otherwise they would harm others or themselves. If we are able

to achieve the same effect chemically, by eliminating the excitement state of the patient, this makes the care of these patients much simpler of course. The relationship of the patient with the surrounding personnel is a much better one, and I would say the certain undertones of force and occasionally even brutality that an excited mental patient provokes in the environment to a very large extent can be controlled and even eliminated.

Some people have the idea that these drugs represent a chemical restraint. In other words, instead of restraining a patient physically or restraining a patient by brute force we are now simply restraining the patient chemically. I should like to allay this misapprehension. These patients are not restrained by the drug. As a result of drug therapy these patients are less tense, less excited, less upset and therefore they function better and behave more normally than before.

From the point of view of the planning of hospitals it is important to mention that if we are able gradually to reduce the number of patients who belong in the disturbed category then we will, of course, need far fewer special facilities for disturbed patients in the hospitals of the future. Psychiatric divisions of general hospitals, for instance, can have liberalized building plans and organization for these patients, because with the use of these drugs the behavior pattern of mental patients as "mental" in many cases is eliminated, and the behavior of these patients will become more and more like the behavior of patients suffering from other diseases. This will help to reduce the special and unjustified stigma which still attaches to a person who is mentally sick and therefore supposedly different from the way he would be if he were physically sick. Basically there is no difference, of course, between the two.

The use of the new drugs would also permit us to organize hospitals where the patient is not hospitalized fully. I am alluding here to the day hospital, of which we still have only very few but which function very well in other countries, especially in Canada. In these hospitals the patients can be brought in in the morning and taken home in the afternoon, receiving during the day the treatment which is necessary. Two such centers are now being established experimentally by the New York State Department of Mental Hygiene.

Disturbed, destructive, very upset patients, of course, cannot be treated in such a setup but if you have the means to control these outstanding features of some mental disorders, as I have described, it will be possible to treat more patients in day hospitals and more patients in clinics than was the case before.

You can ask the question: Do these new drug treatments, which we are using extensively in New York and which, of course, are also extensively used in other states, really influence the admission rate of patients in the hospitals? You read, and you know, that a large number of patients are receiving these drugs on the outside on prescription. But does that really influence the rate of admission to our hospitals?

Our statistics do not show it. In other words, the number of patients admitted to the state institutions is the same as before, and we do not know what the reason is why some of these patients who receive the drugs on the outside are still admitted to the hospitals. The explanation is probably that we do not yet know what kind of patient would need these drugs and in what dosage, so that his condition could be controlled without the necessity of his being admitted to a hospital. It is also possible that the patient's condition has to reach a certain degree before the drugs actually act prop-

erly. For instance, our observation is that these drugs are far more effective for seriously sick mental patients than they are for patients suffering only from mild emotional disorders.

Although the admission rate has not changed under the influence of the drugs, the release rate from the state hospitals is changing. The increase in release rate, of course, is not based on the drugs alone but to a considerable degree, in my opinion, results from the more extensive use of these drugs. This is quite gratifying. During the past fiscal year (1955–56) we released 2,600 more patients from state institutions than during the year before.

With the release of the patient the situation is not solved, however. The relapse rate of the patients after discharge from the hospitals is still a pretty high one. To prevent relapses we shall have to do more for the patients in the community than has been done in the past. We shall have to use more extensive clinic organizations than we have today, and we shall have to staff these clinics, if possible, to such an extent that instead of merely following these patients they will be able to give treatment—to continue giving the drug to the patients and in addition to give the necessary psychotherapy.

Therefore, in hospital organization and planning it has to be emphasized that we have to increase very much the organizational facilities and therapeutic facilities of our clinics. This, of course, also has bearing on clinics which are not run by the state, because they will also increasingly meet the large number of patients who are released from the institutions and who will be treated in the community. These patients have to be maintained in the community if you don't want them to relapse and return to the hospital.

I mentioned to you before that the use of the newer drugs transforms the morale and behavior of many of the wards. Many of the patients improve rapidly and are ready for release sooner than before. Quite a number of the patients improve under these drugs without any additional therapy. How many can do that we do not know, but a very large number of patients improve under the drugs only to such an extent that they need other help. These patients would need, then, occupational therapy, recreation, individual and group psychotherapy.

The staffing in our hospitals at present is inadequate to fulfill this task. This large number of rapidly improving patients will have to be helped along, and somebody will have to be there with whom the patients can discuss some of their difficulties and some of their conflicts. Many of these patients in a stage of induced tranquility are ready to do this, although before being given the new drugs they were not approachable. It means therefore that we shall have to have many more nurses, attendants, social workers and other trained personnel to be able to take care of these patients. Formerly many of these patients became chronic and didn't need this kind of help.

Many always ask when I speak about these topics: Are these drugs really so effective that mental institutions will be closed and that we don't have to build any mental institutions?

The answer is that these drugs are an advance. These drugs, in addition to already existing treatment methods in psychiatry, are new weapons in treating the mentally sick; but they are not on the level of treatments which can wipe out a condition completely. They are not even on the level of penicillin, which is able, of course, to abolish some disease entities nearly completely.

But if it is possible—and I hope it will be possible—to balance the admissions and

the discharges in the state institutions, then, of course, from a long-range point of view it will not be necessary to build as many hospitals as we built before. But the money which formerly went into these hospitals, or at least part of this money, will still have to be used and have to be widely used to increase our therapeutic facilities.

Psychiatry, like any other branch of medicine, is based on treatment. All other activities in psychiatry, training, research and probably many of the others are actually all here to serve one main purpose: namely, the treatment of the patient. Therefore the treatment of the patient will have to be concentrated upon in the future, and we hope that much of the money which probably would have gone into long-range hospital construction can be used to increase the therapeutic facilities in our institutions.

I would like to touch upon one more point of considerable importance. As large numbers of patients are improving, even though they are not fully cured, and they will need further support in the community, the attitude of the community toward these patients is a very important one. Maintenance of a patient in the community, treatment of a mental patient in the community, doesn't depend on the patient alone. It depends also on the attitude of the community toward the patient. If the community is rejective, if its citizens have the feeling that these people should not be among them because they are not 100% cured, that they should be locked up somewhere away from them, this attitude obviously will influence not just the patients who are already in the community but the chances for discharge of those patients still in the hospital.

I believe therefore that the community itself should examine its own attitude toward these patients who are discharged. They need a great deal of help. The chemical help and some of the emotional supportive help we will try to give them, but it is equally important that the community look upon them without stigma, that the community help them regain stature in the social organization, that the community be willing to give them jobs (of great importance) and keep them feeling like full-fledged members of society. If this can be achieved, then I believe that the chemical help which we are giving and the psychotherapeutic help which we are giving will be very much augmented by the attitude of the community. Such an attitude would also lead to a larger number of patients being treated in the community and not in the institutions.

The treatment with drugs—and, of course, some other developments which I cannot go into here about hospital organization and community mental health organization—give us today a great opportunity to reorient the care of the mentally ill. The mentally ill patient should be in a hospital when he requires hospitalization, just as a person should be in a hospital for physical sickness if he requires hospitalization. But he should not be in a hospital if he does not require hospitalization and the patient's admission to a hospital should not be decided on a legal or an administrative basis but on clinical necessity.

If nothing else is accomplished with these newer treatments, I hope they will focus attention on the fact that it can be decided on a clinical basis when a patient should be hospitalized, when a patient should be in a day hospital, when a patient should be treated in a clinic. With such an approach the treatment of the mental patient would be very similar to the treatment of patients suffering from other forms of disease—and this is how it should have been from the beginning.

BENJAMIN MALZBERG, PH.D.

Cohort studies of mental disease in New York State: 1943 to 1949

MANIC-DEPRESSIVE PSYCHOSES

First admissions with manic-depressive psychoses to the New York civil state hospitals have shown a marked downward trend for many years. In 1930, for example, there were 1,160 such first admissions, or 9.2 per 100,000 of general population. In 1940, despite an increase of population, there were only 794 such first admissions, or a rate of 5.9. By 1950 the number of such first admissions had fallen still further to 373, or a rate of 2.5. In 1930 first admissions with manic-depressive psychoses represented 12.8% of all first admissions and were exceeded in number only by dementia praecox and psychoses with cerebral arteriosclerosis. By 1940 the manic-depressive psychoses represented only 6.1% of all first admissions and ranked sixth in order of frequency. In 1950 they were seventh in order of frequency and included only 2.3% of the total first admissions.

The downward trend is frequently referred to as an artifact resulting from a shifting in diagnostic criteria. It is difficult to believe, however, that the steady downward trend in such first admissions has resulted merely from a continued change in diagnoses year after year. If there were no secular trend in the frequency of the manic-depressive psychoses it would have been more reasonable to expect a sudden drop followed by a stabilization in the relative number of such admissions. It appears more reasonable therefore to assume that the downward trend is related to a change in the frequency of such psychoses. It has also been suggested that first admissions

Dr. Malzberg was formerly the director of statistics for the New York State Department of Mental Hygiene. These are the 7th and 8th of a series of 9 reports based on an investigation supported by a research grant from the National Institute of Mental Health.

with manic-depressive psychoses have decreased because many such patients are now being treated privately by means of convulsive therapies. This is undoubtedly true in part. However, the downward trend in such first admissions began long before the introduction of these therapies.

The following analysis of the outcome of treatment of manic-depressive psychoses is based upon a total of 2,474 such first admissions to the New York civil state hospitals. These admissions belonged to five annual cohorts admitted during five successive fiscal years beginning with the fiscal year 1943–44. The members of the first cohort were each followed for a period of exactly five years from the date of admission to a closing date during fiscal year 1948–49. The period of hospitalization was one year less for each successive cohort. The maximum for the final cohort, that of 1947–48, was therefore one year. Rates of discharge and of mortality during specified periods after first admissions are therefore averages derived from the experiences of the cohorts who were under exposure during these periods.

Table I shows the number of first admissions in each cohort. In accordance with the downward trend noted previously, it will be observed that the cohorts decreased from a total of 564 in 1943–44 to 402 in 1947–48.

The age distribution of the 2,474 first admissions is summarized in Table II. The median age at first admission was 39.1 years. Just under 56% were within the ages of 25 and 44 years. Females were admitted at a significantly younger age than males. Their median age was 37.7 years and fewer than 30% were aged 45 or over. Males, on the contrary, had a median age of 43.3 years and almost half were aged 45 or over. These relative differences in age are related to subsequent differences in rates of discharge and of mortality.

Of the male cohorts an average of 82.6% were discharged from the books within five years after hospitalization. This high percentage may be compared with an average of 42% for all male first admissions. Even first admissions with alcoholic psychoses, with many discharges, averaged only 65.6%. Those with involutional psychoses averaged 68.2%.

Discharges were relatively numerous dur-

TABLE I

First admissions with manic-depressive psychoses to New York civil state hospitals, fiscal years 1943–44 to 1947–48 inclusive

FISCAL YEAR	MALES	FEMALES	TOTAL
1943–44	154	410	564
1944–45	129	414	543
1945–46	156	333	489
1946–47	151	325	476
1947–48	155	247	402
Total	745	1,729	2,474

TABLE II

First admissions with manic-depressive psychoses to New York civil state hospitals, fiscal years 1943–44 to 1947–48 inclusive, classified according to age

AGE (years)	NUMBER			PERCENT		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*
15–19	22	49	71	3.0	2.8	2.9
20–24	43	148	191	5.8	8.6	7.7
25–29	56	201	257	7.5	11.6	10.4
30–34	65	285	350	8.7	16.4	14.1
35–39	110	335	445	14.8	19.4	18.0
40–44	116	217	333	15.6	12.6	13.4
45–49	86	159	245	11.5	9.2	9.9
50–54	67	130	197	9.0	7.5	8.0
55–59	82	82	164	11.0	4.7	6.6
60 or over	97	119	216	13.0	6.9	8.7
unascertained	1	4	5	0.1	0.2	0.2
Total	745	1,729	2,474	100.0	100.0	100.0

ing the first three months, as shown in Table III. A fifth of the male cohorts were discharged during this period. Discharges were few, however, during the remainder of the first year and increased to only 27.2% of the total male cohorts for the entire year. The period of most rapid discharge was the second year. Almost half of the cohorts, 48.8%, were discharged during this period. Thus, 76.0% of the male cohorts were discharged within two years after admission. Almost 80% of those discharged from the books during the second year had been placed in convalescent care during the first year. Therefore two-thirds of the male first admissions with manic-depressive psychoses left the hospitals during the first year of hospitalization, either by direct discharge or by placement in convalescent care. According to a study of a corresponding cohort of male first admissions during 1909–10 (1), 43.8% had left the hospitals within a year and 59.7% were discharged within five years. These include discharges following readmissions. On a similar basis the adjusted percentage for the current male cohorts would be 60 at the end of the year and 75 at the end of the fifth year. Both were significantly in excess of the earlier results.

Of the female cohorts 14.9% were discharged within three months after hospitalization. This grew to 21.3% by the end of the first year. As shown in the table, 57% of the cohorts were discharged during the second year. By the end of the fifth year 86.7% had been discharged, compared with 82.6% of the males. Of all female first admissions 43.5% were discharged within five years. For the alcoholic psychoses and

TABLE III

First admissions with manic-depressive psychoses to New York civil state hospitals discharged during specified periods after admission, classified according to percentage and rate

PERIOD OF HOSPITALIZATION	MALES			FEMALES		
	Percent	*Cumulative percent*	*Rate per 1,000 exposures* *	*Percent*	*Cumulative percent*	*Rate per 1,000 exposures* *
First three months	20.4	20.4	847.0	14.9	14.9	612.5
Second three months	4.1	24.5	224.4	3.8	18.7	187.6
Third three months	1.6	26.1	92.8	1.3	20.0	69.1
Fourth three months	1.1	27.2	63.6	1.3	21.3	70.7
First year	27.2	27.2	281.4	21.3	21.3	218.7
Second year	48.8	76.0	750.0	57.0	78.3	767.6
Third year	4.6	80.6	327.9	6.1	84.4	390.0
Fourth year	1.4	82.0	166.7	1.9	86.3	250.0
Fifth year	0.6	82.6	83.3	0.4	86.7	108.1

* On an annual basis.

the involutional psychoses the corresponding percentages were 70 and 69.6 respectively.

Of those discharged during the second year 80% had been placed in convalescent care during the previous year. Thus from 70% to 75% had left the hospitals during the first year, either by direct discharge or by placement in convalescent care. Of a corresponding cohort of female first admissions during 1909–10 (2), 38.3% had left the hospitals within a year. By the end of the fifth year 54.5% had left. Adjusting the current cohorts with respect to readmissions we obtain corresponding percentages of 65 and 75 for the current female cohorts.

We may consider next rates of discharge per 1,000 annual exposures during specified periods following first admission. Males began with a rate of 847 per 1,000 annual exposures during the first three months. The rate decreased rapidly during the remainder of the first year and averaged 281.4 for that period. The rate rose during the second year to 750 as a result of discharges from convalescent care. The rate then dropped to a minimum of 83.3 during the fifth year.

Females began with a rate of 612.5 per 1,000 annual exposures during the first three months. The rate dropped to 70.7 during the final quarter and averaged 218.7 for the entire year. This was lower than the corresponding rate for males. In subsequent years females had higher rates than males. The rate rose to a maximum of 767.6 during the second year and dropped to a minimum of 108.1 during the fifth year.

Among a corresponding male cohort in 1909–10 (3) the rate of discharge within two

years after hospitalization was 545 per 1,000 exposures. The current male cohorts had a corresponding rate of 797. When corrected for readmissions the rate for the current cohorts was reduced to 733. The early female cohort had a discharge rate of 510 during the first two years (3), compared with 797 for the current cohorts of females. When adjusted for the readmissions the rate for the latter became 680. Thus the current rates of discharge were far in excess of those that prevailed forty years ago.

TABLE IV

*Rates of discharge * among first admissions with manic-depressive psychoses to the New York civil state hospitals during specified periods after admission, classified according to age at first admission*

AGE AT FIRST ADMISSION (years)	1st three mos.†	2nd three mos.†	3rd three mos.†	4th three mos.†	1st year	2nd year	3rd year	4th year	5th year
					MALES				
15–19	(1000.0)	–	266.7	571.4	418.6	800.0	–	1000.0	–
20–24	(1000.0)	428.6	320.0	347.8	476.2	875.0	500.0	–	–
25–29	737.3	454.5	314.8	–	350.3	653.8	333.3	–	–
30–34	(1000.0)	416.7	95.0	–	356.6	882.4	666.7	–	–
35–39	(1000.0)	202.2	106.7	109.6	324.1	807.4	333.3	–	333.3
40–44	895.9	232.6	49.4	50.0	281.9	885.7	500.0	–	–
45–49	902.1	63.2	64.5	65.6	261.9	659.3	444.4	500.0	–
50–54	665.4	150.2	–	–	198.4	821.9	333.3	–	–
55–59	685.4	327.2	–	–	230.8	615.4	–	–	–
60 or over	488.9	54.3	56.2	–	146.1	563.1	285.7	333.3	–
					FEMALES				
15–19	408.2	–	90.9	93.0	142.9	666.7	700.0	–	1000.0
20–24	410.3	274.8	–	66.1	177.4	818.6	533.3	500.0	–
25–29	639.6	190.4	150.0	155.8	259.4	822.1	187.5	444.4	–
30–34	755.4	247.7	75.4	38.6	259.3	806.1	250.0	250.0	400.0
35–39	579.4	203.5	76.6	78.4	216.4	795.3	437.5	333.3	–
40–44	550.1	223.2	71.7	24.4	203.3	754.3	510.6	–	–
45–49	732.6	64.5	33.3	102.3	221.4	776.7	400.0	250.0	–
50–54	835.3	123.6	43.0	87.0	260.2	689.7	333.3	–	–
55–59	312.7	178.1	–	–	117.6	747.7	300.0	–	–
60 or over	553.0	43.4	90.5	47.4	171.9	583.3	304.3	428.5	–

* Per 1,000 annual exposures.
† On an annual basis.

Table IV shows the variation of rates of discharge with increasing age at first admission. As with the other groups of mental disorders the rates showed a downward trend as age increased. Among males the rate of discharge per 1,000 annual exposures was 400 or over during the first year of hospitalization at the youngest ages. The rate decreased to a minimum of 146 at age 60 or over. During the second year the rate of discharge decreased from over 800 at the youngest ages to approximately 600 at the oldest ages. Discharge rates among the female cohorts showed a similar inverse relation to age at admission. During the first year they rose to 259 at ages under 35 years, then decreased significantly with advancing age. During the second year they decreased from over 800 at the younger ages to approximately 600 at the oldest ages. During the third year they decreased from 700 to 300 in accordance with advancing age at admissions.

Table V describes the condition of the patients at the time of discharge. The discharge period was taken as two years after admission, since 90% of the discharges occurred within this period. Statistics for this period were available for the first four cohorts. The fifth cohort could not be included, as its exposure was for a period of only one year.

Of the 2,072 admissions with manic-depressive psychoses included in the four cohorts 978, or 47.2%, were discharged as recovered; 398, or 19.2%, were discharged as much improved; 176, or 8.4%, were dis-

TABLE V

Discharges among first admissions with manic-depressive psychoses to New York civil state hospitals, fiscal years 1943–44 to 1946–47 inclusive, within two years after admission, classified according to condition at discharge

CONDITION AT DISCHARGE	MALES			FEMALES			TOTAL		
	Number	*Percent of total discharges*	*Percent of first admissions*	*Number*	*Percent of total discharges*	*Percent of first admissions*	*Number*	*Percent of total discharges*	*Percent of first admissions*
Recovered	260	57.9	44.1	718	62.5	48.4	978	61.2	47.2
Much improved	128	28.5	21.7	270	23.5	18.2	398	24.9	19.2
Improved	54	12.0	9.2	122	10.6	8.2	176	11.0	8.4
Unimproved	7	1.6	1.2	38	3.3	2.6	45	2.8	2.2
Total discharges	449	100.0	76.1	1,148	100.0	77.4	1,597	100.0	77.1
Total first admissions	590	–	–	1,482	–	–	2,072	–	–

charged as improved. Thus 74.8% were discharged within two years with some degree of improvement. Percentages of recovery were 44.1 and 48.4 for males and females respectively. All degrees of improvement were 75.0% and 74.8% for males and females respectively.

These may be compared with corresponding results for the cohorts of 1909–10 (4). The male cohort had a recovery rate of 34.7%; all degrees of improvement totaled 48.7%. Among the female cohort of 1909–10 the corresponding percentages were 33.2 and 43.7 respectively. It is thus clear that first admissions with manic-depressive psychoses now have rates of discharge significantly higher than those for earlier cohorts and that higher percentages have either recovered or improved in some lesser degree. These changes, which followed the introduction of the convulsive shock therapies, must be attributed to the effective use of these modes of treatment.

MORTALITY

Mortality was low among the cohorts of first admissions with manic-depressive psychoses. Only 9.7% of the male cohorts died within five years after hospitalization, compared with 39% of all first admissions. Two-thirds of the mortality occurred during the first year. Within this period the mortality was heaviest during the first three months.

Of the female cohorts 6.2% died within five years. Three-fourths of the deaths occurred during the first year. As with males, most of the deaths among females occurred

TABLE VI

First admissions with manic-depressive psychoses to New York civil state hospitals dying during specified periods after admission, classified according to percentage and rate

PERIOD OF HOSPITALIZATION	MALES			FEMALES		
	Percent	*Cumulative percent*	*Rate per 1,000 exposures* *	*Percent*	*Cumulative percent*	*Rate per 1,000 exposures* *
First three months	4.2	4.2	202.6	3.4	3.4	154.2
Second three months	1.4	5.6	82.3	0.4	3.8	23.6
Third three months	0.4	6.0	23.6	0.6	4.4	27.3
Fourth three months	0.3	6.3	16.1	0.4	4.8	24.8
First year	6.3	6.3	73.0	4.8	4.8	53.7
Second year	2.7	9.0	64.5	0.6	5.4	13.2
Third year	–	9.0	–	0.6	6.0	47.3
Fourth year	0.7	9.7	87.0	–	6.0	–
Fifth year	–	9.7	–	0.2	6.2	55.6

* On an annual basis.

during the first three months of hospitalization.

Of the male cohort of 1909–10, 11.3% died within five years (5), compared with 9.7% of the current male cohorts. The relative mortality was slightly higher during the first two years among the current male cohorts but was lower in the subsequent years.

Among females (5) the mortality was significantly lower for the current groups of cohorts. Thus only 6.2% of the current

TABLE VII

*Rates of mortality * among first admissions with manic-depressive psychoses to New York civil state hospitals during specified periods after admission, classified according to age at first admission*

AGE AT FIRST ADMISSION (years)	1st three mos.†	2nd three mos.†	3rd three mos.†	4th three mos.†	1st year	2nd year	3rd year	4th year	5th year
					MALES				
15–19	238.8	–	–	–	57.1	–	–	–	–
20–24	253.0	–	–	–	60.6	–	–	–	–
25–29	169.3	–	110.0	–	63.8	–	–	–	–
30–34	–	–	95.0	–	18.7	–	–	–	–
35–39	138.9	52.3	–	–	43.2	30.3	–	–	–
40–44	212.4	–	–	–	50.0	50.0	–	–	–
45–49	115.3	124.8	–	–	53.3	9.4	–	–	–
50–54	69.7	150.2	–	–	49.6	45.4	–	–	–
55–59	396.4	69.4	–	–	109.6	137.9	–	–	–
60 and over	366.3	259.3	56.2	114.3	176.8	126.6	–	333.3	–
					FEMALES				
15–19	–	–	–	–	–	–	–	–	–
20–24	59.3	–	32.8	–	22.2	15.6	166.7	–	–
25–29	23.1	–	–	–	5.7	13.3	–	–	–
30–34	83.8	18.6	–	19.4	28.2	–	–	–	400.0
35–39	163.3	15.2	–	15.9	46.7	15.3	–	–	–
40–44	146.1	46.4	48.1	–	56.3	11.0	55.6	–	–
45–49	208.2	–	66.1	68.7	77.4	–	–	–	–
50–54	223.8	41.9	43.0	–	70.2	20.8	–	–	–
55–59	312.7	178.1	–	125.0	141.9	29.4	210.5	–	–
60 and over	453.4	–	134.4	94.0	155.3	38.4	97.6	–	–

* Per 1,000 annual exposures

† On an annual basis

group died within five years, compared with 11.3% of the early female cohort. Unlike the males, the early female cohort showed higher mortality during each specified period following admission.

Table VI shows rates of mortality per 1,000 annual exposures. The male cohorts began with a rate of 202.6 during the first three months of hospitalization. The rate dropped rapidly during the remainder of the year and averaged 73.0 for the first year. This decreased to 64.5 during the second year. Among females the rate of mortality was 154.2 during the first three months and averaged 53.7 for the first year. The rate dropped to 13.2 during the second year. Rates of mortality fluctuated fortuitously after the second year because of the few exposures after that period.

Since the majority of deaths occurred during the first year it is of interest to compare the relative mortality during this period among the two sets of cohorts. For males the rate of mortality per 1,000 annual exposures was as follows: current cohorts, 73.0; early cohort, 81.1 (6). For females the corresponding rates were 53.7 and 94.8 respectively (6). We conclude that mortality has decreased significantly in recent years among first admissions with manic-depressive psychoses.

Table VII shows rates of mortality per 1,000 annual exposures during specified periods after admission in relation to age at first admission. Previous analyses showed that such rates increased with advancing age at first admission. Since first admissions with manic-depressive psychoses are relatively few among males the rates fluctuated irregularly. Nevertheless it is clear that within each period after admission the rates were highest among the oldest groups (*i.e.*, age 55 or over). Females, with their larger number of admissions with such psychoses, had more stable trends. Thus their rates of mortality rose steadily during the first three months to a maximum of 453.4 per 1,000 annual exposures among those admitted at age 60 or over. During the first year the rates rose to a maximum of 155.3. During

TABLE VIII

Percent of first admissions with manic-depressive psychoses to New York civil state hospitals remaining in continuous residence at the end of specified periods after admission

END OF	MALES	FEMALES
Third month	75.4	81.8
Sixth month	69.8	77.5
Ninth month	67.8	75.7
First year	66.4	73.9
Second year	14.9	16.9
Third year	9.3	9.2
Fourth year	6.7	5.8
Fifth year	5.7	3.9

the second year they rose to a maximum of 38.4.

Table VIII shows the percentage of the original cohorts remaining continuously on the books of the New York civil state hospitals at the end of specified periods after admission. After three months only 75.4% of the males were still on the books. By the end of the first year the percentage was reduced to 66.4. Because of the expiration of periods of convalescent care during the second year the discharges from the books increased so that only 14.9% of the cohorts were still on the books at the end of this period. At the end of the fifth year only 5.7% were still on the books.

During the first two years the percentages of females on the books exceeded the corresponding percentages for males. At the end of three months 81.8% of the females were still on the books. By the end of the first year this was reduced to 73.9%. After the second year their rate of reduction exceeded that of the males.

The median duration was 15.7 months for males and 17.0 months for females.

Of the male cohort of 1909–10, 12.0% (7) were still on the books after five years, including those who had been readmitted during this period. Of the female cohort 19.2% (7) were still on the books. Among the current cohorts the percentages on a comparable basis were 13.6 for males and 12.0 for females.

SUMMARY

This study of average rates of discharge and of mortality among first admissions with manic-depressive psychoses was based upon the experience of five successive annual cohorts of such admissions to the New York civil state hospitals beginning with fiscal year 1943–44 and ending with fiscal year 1947–48. These cohorts included 2,474 first admissions, of whom 745 were males and 1,729 were females.

Of the male cohorts 82.6% were discharged from the books within five years after hospitalization. Almost half the discharges occurred during the second year following the termination of convalescent care during this period. Discharges were most rapid, however, during the first three months, when 20.4% of the first admissions were discharged, representing a rate of 847 per 1,000 annual exposures. Of the female cohorts 86.7% were discharged within five years after admission. More than half the females were discharged during the second year following discharge from convalescent care. The average rate of discharge during the first year was 218.7 per 1,000 annual exposures. The rate reached a maximum of 767.6 during the second year.

Of a cohort of male first admissions with manic-depressive psychoses during 1909–10, 43.8% left the hospitals within a year, either by direct discharge or by placement in convalescent care, and 59.7% left within five years. On a comparable basis the percentages for the current male cohorts were 60 and 75 respectively. For female cohorts the percentages were as follows: cohort of 1909–10 discharged within a year, 38.3; discharged within five years, 54.5. Of the current cohorts 65% were discharged within a year and 75% were discharged within five years.

Not only was the rate of discharge higher for the current cohorts but higher percentages were discharged with some degree of improvement. Thus within two years after admission 44.1% of the current male cohorts were discharged as recovered, compared with 34.7% of the early male cohort. With respect to all degrees of improvement the corresponding percentages were 75.0 and 48.7 respectively. For females the corre-

sponding percentages of recovery were 48.4 and 33.2 respectively. For all degrees of improvement they were 74.8 and 43.7 respectively. Improvement with respect to rates of discharge and condition at discharge must both be attributed to the use of the convulsive shock therapies.

Mortality was low. Of the male cohort 9.7% died within five years. Almost half the deaths occurred within the first three months. Mortality was still lower among the female cohorts, of whom 6.2% died within five years. Half the deaths occurred during the first three months. Mortality was higher among the earlier cohorts of 1909–10. Of the males 11.3% died within five years, compared with 9.7% of the current male cohorts. Among females the corresponding percentages were 11.3 and 6.2 respectively.

As a result primarily of high rates of discharge the percentage of first admissions with manic-depressive psychoses who remained continuously on the books was reduced rapidly. A fourth of the male cohorts was removed within three months; a third was removed by the end of the first year. Placement in convalescent care was frequent. As a result of the termination of such care during the second year only 14.9% of the male cohorts was still on the books at the end of that year. At the end of five years the percentage was reduced still further to 5.7.

Females had a lower rate of decrement than males during the first two years. Almost three-fourths were still on the books at the end of the first year. As with males, there was a great decrease during the second year, 16.9% remaining at the end of that year. Compared with discharges of males, discharges of females were more rapid after the second year and only 3.9% of the females were still on the books at the end of the fifth year.

PART VIII. DEMENTIA PRAECOX

First admissions with dementia praecox have always constituted the largest group of admissions to the New York civil state hospitals. When first recorded in 1909 they represented 19.8% of the total first admissions. By 1920 they had increased so rap-

TABLE I

First admissions with dementia praecox to New York civil state hospitals, fiscal years 1943–44 to 1947–48 inclusive

FISCAL YEAR	MALES	FEMALES	TOTAL
1943–44	1,189	1,752	2,941
1944–45	1,142	1,813	2,960
1945–46	1,218	1,926	3,144
1946–47	1,558	2,024	3,582
1947–48	1,734	2,210	3,944
Total	6,841	9,730	16,571

TABLE II

First admissions with dementia praecox to New York civil state hospitals, fiscal years 1943–44 to 1947–48 inclusive, classified according to age

AGE (*years*)	NUMBER			PERCENT		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*
Under 15	120	82	202	1.8	0.8	1.2
15–19	845	758	1,603	12.4	7.8	9.7
20–24	1,174	1,448	2,622	17.2	14.9	15.8
25–29	1,091	1,668	2,759	15.9	17.1	16.6
30–34	1,076	1,652	2,728	15.7	17.0	16.5
35–39	845	1,493	2,338	12.4	15.4	14.1
40–44	681	976	1,657	10.0	10.0	10.0
45–49	434	670	1,104	6.3	6.9	6.7
50–54	288	451	739	4.2	4.6	4.4
55–59	164	273	437	2.4	2.8	2.6
60 or over	118	246	364	1.7	2.5	2.2
Unascertained	5	13	18	0.1	0.1	0.1
Total	6,841	9,730	16,571	100.0	100.0	100.0

idly that they represented 29.3% of all first admissions. Dementia praecox continued as the leading category for the next two decades but because of the great growth of first admissions associated with advanced age their percentage of the total declined to 23.6 in 1944. The trend changed again after World War II and since 1945 first admissions with dementia praecox have included an increasing percentage of the total first admissions, currently averaging 29% of the total. Corresponding rates of first admissions per 100,000 general population have increased from approximately 19 in 1920 to 31 in 1950. Thus dementia praecox is not only the largest of the groups of mental disorders but it has increased over a long span of years. Consequently the average rates of discharge and of mortality among all first admissions to the New York civil state hospitals are influenced to a high degree by the rates for those with dementia praecox.

The following analysis is based upon the experience of five cohorts of first admissions with dementia praecox to the New York civil state hospitals beginning with the fiscal year 1943–44.

The five cohorts included a total of 16,571 first admissions, of whom 6,841 were males and 9,730 were females. This total excludes 630 first admissions with dementia praecox who had left the state hospital system either by transfer or readmission to a mental hospital outside the state hospital system. It will be noticed that the admissions totaled only 2,941 during 1943–44, a war year. Subsequently they increased to a total of 3,944 during 1947–48. It may also be noted that female first admissions ex-

ceeded males. This excess began in 1941 and was probably related in part to the withdrawal of a large segment of the general male population into the armed forces. Since the war many males who might have entered a state hospital have been admitted to other hospitals, such as those of the U. S. Veterans Administration. However, this does not furnish a complete explanation of the change in the sex ratio of first admissions with dementia praecox and it is therefore necessary to reconsider earlier impressions that dementia praecox is more frequent among males than females.

The age distribution of the 16,571 first admissions is shown in Table II. They were concentrated within the ages of 15 and 44, 83% of the total being within this range. The median age was 32.0 years. Males were younger than females. Of the former, 2,139, or 31.3%, were under age 25. The corresponding percentage for females was 23.5. The median ages were 30.9 and 32.7 years for males and females respectively.

Table III shows the discharges during successive intervals following admission. Of the total male cohorts 65.5% were discharged from the books within five years, compared with 42% of all male first admissions. The percentage compares favorably with those for the alcoholic psychoses and involutional psychoses and is exceeded only by the percentage of 82.6 for the manic-depressive psychoses. Of the total admissions with dementia praecox 15.7% were discharged during the first year of hospitalization. Almost half these discharges occurred during the first three months. The second year was the period of most rapid discharge largely because of the expiration of placements in convalescent care during

TABLE III

First admissions with dementia praecox to New York civil state hospitals discharged during specified periods after admission, classified according to percentage and rate

PERIOD OF HOSPITALIZATION	MALES			FEMALES		
	Per-cent	*Cumula-tive percent*	*Rate per 1,000 exposures* *	*Per-cent*	*Cumula-tive percent*	*Rate per 1,000 exposures* *
First three months	7.4	7.4	301.5	5.6	5.6	228.1
Second three months	4.3	11.7	171.2	3.4	9.0	147.7
Third three months	2.3	14.0	105.8	1.7	10.7	75.1
Fourth three months	1.7	15.7	80.3	1.1	11.8	49.7
First year	15.7	15.7	158.6	11.8	11.8	119.3
Second year	36.8	52.5	454.2	39.7	51.5	467.5
Third year	7.9	60.4	176.9	7.2	58.7	158.9
Fourth year	3.2	63.6	87.6	2.6	61.3	68.5
Fifth year	1.9	65.5	57.2	1.4	62.7	37.4

* On an annual basis

this period. There were relatively few discharges after the second year. Of those leaving the hospital during the second year approximately 75% had been placed in convalescent care during the first year. Therefore it may be estimated that 45% of the male first admissions with dementia praecox had left the hospitals within a year, either by direct discharge or by placement in convalescent care.

Of a cohort of male first admissions with dementia praecox in 1909–10 (1), 22.7% had left the hospitals within a year and 34.5% had left by the end of the fifth year of hospitalization. These include discharges following readmissions. On a similar basis the corresponding percentages for the current male cohorts would have been 40 and 60 respectively. Both are significantly in excess of the discharges among the earlier cohort.

Of the female first admissions with dementia praecox 62.7% were discharged within five years, compared with 43.5% of all female first admissions. This was less than the corresponding percentages for first admissions with alcoholic or involutional psychoses and also significantly less than that for the manic-depressive group. As with the males, half of the female admissions were discharged during the first two years. The second year was the period of most rapid discharge, owing to the termination of convalescent care. Approximately 40% of the females had left the hospitals during the first year either by direct discharge or by placement in convalescent care.

Of a corresponding cohort of female first admissions in 1909–10 (2), 14.3% had left within a year and 25.3% had been discharged by the end of the fifth year of hospitalization. If we correct for readmissions and placement in convalescent care the corresponding percentages for the current female cohorts would be 35 and 55 respectively. Both are in significant excess over the results for the earlier cohort.

Table III shows average discharge rates per 1,000 annual exposures during successive periods after hospitalization. Males began with a rate of 301.5 during the first three months. There was a rapid reduction in the rate of discharge during the remainder of the first year, the rate reaching 80.3 during the final quarter of the year. The average for the year was 158.6. The rate rose to 454.2 during the second year, which was associated largely with discharge from convalescent care, then dropped steadily to 57.2 during the fifth year.

Females had lower discharge rates than males. They began with a rate of 228.1 during the first three months. This was followed by a downward trend during the remainder of the year, culminating in a rate of 49.7 in the final quarter. The average for the first year was 119.3. The rate rose to a maximum of 467.5 during the second year, then declined to a minimum of 37.4 during the fifth year.

Comparison may be made with the earlier cohorts on the basis of discharge during the first two years after admission. This eliminates almost entirely the differences arising from the use of convalescent care. During this period the current male cohorts had a discharge rate of 536.4 per 1,000 exposures. The corresponding rate for the earlier male cohort of 1909–10 was only 280.9 (3). For females the corresponding rates were 526.6 and 214.0 respectively. Rates of discharge for the current cohorts were based upon discharges subsequent to continuous residence in the hospitals. Rates for the earlier cohorts were reduced by the inclusion of readmissions. When allowance is made for this factor the current rates of discharge were still in excess by 75% for males and by more than 100% for females.

The evidence is clear, therefore, that there has been a remarkable improvement in rates of discharge among first admissions with dementia praecox. There is general agreement that this has resulted from the introduction of the newer methods of shock therapy. Nevertheless there are some who feel that changes in diagnostic fashions may account for the higher level of current discharges. The point is made that many

TABLE IV

*Rates of discharge * among first admissions with dementia praecox to New York civil state hospitals during specified periods after admission, classified according to age at first admission*

AGE AT FIRST ADMISSION (*years*)	*1st three mos.*†	*2nd three mos.*†	*3rd three mos.*†	*4th three mos.*†	*1st year*	*2nd year*	*3rd year*	*4th year*	*5th year*
					MALES				
Under 15	200.0	350.9	346.2	84.2	225.0	294.1	197.2	170.2	–
15–19	327.6	243.8	165.9	132.8	200.7	531.4	292.1	110.4	25.0
20–24	379.0	282.9	148.6	90.0	207.1	491.1	205.9	148.1	60.0
25–29	406.6	201.9	139.4	72.3	191.0	473.1	172.0	103.4	30.5
30–34	318.3	167.9	107.2	97.3	162.4	477.9	168.4	115.8	76.2
35–39	311.2	163.1	77.0	107.0	155.0	469.8	149.8	63.6	53.6
40–44	214.4	107.7	45.7	33.3	96.9	463.3	137.7	53.8	95.2
45–49	104.1	118.1	20.4	30.9	66.1	383.3	184.0	16.4	71.4
50–54	197.4	90.1	15.5	31.3	81.4	268.4	134.7	18.2	85.1
55–59	73.6	25.1	–	26.3	31.3	287.0	87.0	31.3	83.3
60 or over	–	110.0	–	39.2	35.9	227.0	98.8	81.6	–
					FEMALES				
Under 15	394.4	164.4	57.1	58.0	159.5	212.8	344.8	142.9	500.0
15–19	270.4	250.7	133.7	56.6	166.8	574.9	241.8	101.9	83.3
20–24	321.4	219.6	109.8	69.8	168.5	573.9	165.2	99.3	42.6
25–29	266.0	200.3	76.8	67.2	144.4	508.3	202.8	78.4	21.6
30–34	237.6	146.5	106.2	30.8	124.2	504.3	175.9	114.1	31.3
35–39	205.9	126.6	44.8	48.4	102.4	471.7	161.2	41.1	59.6
40–44	184.6	75.3	31.7	45.8	81.3	395.3	120.9	48.8	29.6
45–49	134.0	50.8	51.4	45.9	68.3	327.6	107.2	73.5	26.8
50–54	155.0	57.4	48.8	–	63.4	326.3	96.6	34.4	–
55–59	75.7	46.7	–	32.4	38.0	292.6	93.8	–	–
60 or over	16.9	35.0	53.7	74.2	42.8	168.2	83.8	–	45.4

* Per 1,000 annual exposures

† On an annual basis

who were formerly diagnosed as manic-depressive are now being classified as dementia praecox. Since manic-depressives have a high rate of discharge there is the possibility that rates of discharge for dementia praecox such as are reported above should in fact be attributed in part to the inclusion of manic-depressives.

To meet this objection we may consider rates of discharge among the combined cohorts of first admissions with manic-depressive psychoses and dementia praecox. On this basis we find that weighted average percentages of discharge within five years after hospitalization were as follows: current male cohorts, 67.2; early male cohort, 37.0. For females the corresponding percentages were 65.1 and 28.2 respectively. Clearly, therefore, the improvement in rate of discharge was not an artifact arising from misclassifications in diagnosis.

Table IV summarizes the rates of discharge in relation to increasing age at first admission. As with all other groups of mental disorders there was an inverse relation, the rates decreasing as age at first admission increased. Among males the rate of discharge per 1,000 annual exposures decreased during the first year of hospitalization from 225.0 for those aged less than 15 years at admission to approximately 30 at ages 55 or over. During the second year the rates decreased from over 500 at ages 15 to 19 to a minimum of 227 among those aged 60 or over. Similar trends are apparent during the third and fourth years of hospitalization.

For females the rates of discharge during the first year decreased from approximately 160 among the youngest groups at admission to approximately 40 among the oldest. During the second year the rates declined with advancing age from 570 to less than 200. During the third year of hospitalization they declined from over 300 at the youngest ages to 84 at ages 60 or over.

There is a general impression that the shorter the duration of the mental disorder before hospitalization the better is the chance for improvement and discharge. Supporting evidence for this may be found in Table V. We may draw a dividing-line between those with previous histories of less than a year and those with histories of more than a year. Allowing for those with unknown durations and statistical fluctuations, it is evident that males with short previous histories had a higher rate of discharge during the first year of hospitalization. This is even more evident during the second year of hospitalization. The rates of discharge declined steadily from a maximum among those with short durations. In general, the experience during the third and fourth years verifies this trend. The results for females were similar to those for males. During the second year the rates decreased steadily from 642.9 among those with a previous duration of less than a month to a minimum of 238.3 among those with durations of five or more years. During the third year they decreased from 292.0 to 108.7.

Table VI shows the condition of the patients at the time of discharge. As with the groups of mental disorders analyzed previously, the period of discharge was taken as two years after admission. Over 80% of the discharges occurred during this period. Since the fifth cohort was included in the study for only one year, it could not enter into this computation.

Of the 12,627 first admissions with dementia praecox included in the first four cohorts 1,831, or 14.5%, were discharged as recovered; 2,615, or 20.7%, were discharged as much improved; and 1,550, or 12.3%, were discharged as improved. Thus 47.5% were discharged within two years

after hospitalization with some degree of improvement, including recovery. Percentages of recovery were 11.9 and 16.3 for males and females respectively. Percentages of all degrees of improvement were 46.8 and 48.0 for males and females respectively.

Corresponding data are available for the cohorts of 1909–10 (8). The male cohort showed only 2.0% discharged as recovered within two years and 14.8% discharged with all degrees of improvement. These may be compared with corresponding percentages

TABLE V

*Rates of discharge * among first admissions with dementia praecox to New York civil state hospitals during specified periods after admission, classified according to duration of mental disease before admission*

DURATION OF MENTAL DISEASE BEFORE ADMISSION	*1st three mos.†*	*2nd three mos.†*	*3rd three mos.†*	*4th three mos.†*	*1st year*	*2nd year*	*3rd year*	*4th year*	*5th year*
					MALES				
Under 1 month	346.7	104.3	101.6	92.3	151.7	584.8	194.6	92.1	62.5
1–3 months	283.5	140.6	70.2	80.7	136.4	521.5	194.0	107.0	83.3
4–6 months	278.2	301.1	122.4	75.9	180.6	497.2	228.1	87.0	27.0
7–11 months	323.1	293.0	158.6	165.3	215.5	420.7	208.3	129.9	66.6
1 year	291.9	210.5	126.1	61.4	162.1	428.8	155.6	85.1	27.8
2 years	269.8	227.9	165.6	57.9	169.5	400.0	241.2	81.6	44.4
3 years	238.4	176.4	208.1	131.7	175.1	351.6	96.0	31.2	142.8
4 years	246.2	231.2	35.1	141.6	154.4	265.8	257.1	111.1	125.0
5 years or over	279.9	171.2	110.2	31.0	141.0	301.6	119.3	62.5	54.0
					FEMALES				
Under 1 month	258.4	146.0	70.6	41.8	122.6	642.9	292.0	114.0	37.0
1–3 months	216.7	132.4	65.3	53.4	111.4	577.6	193.4	76.8	39.7
4–6 months	335.7	229.3	110.6	66.4	174.0	526.8	170.2	65.8	59.4
7–11 months	287.2	223.2	61.7	41.9	145.4	468.9	134.6	111.1	45.4
1 year	183.9	154.0	68.9	47.0	109.0	395.6	146.2	104.0	54.8
2 years	238.3	164.4	78.1	47.9	126.1	347.0	103.2	69.7	41.2
3 years	187.6	222.1	91.5	67.1	135.1	287.0	138.9	35.7	–
4 years	129.4	95.7	78.4	40.0	82.8	253.4	120.4	66.7	–
5 years or over	137.5	84.4	51.1	20.8	71.4	238.3	108.7	25.2	31.4

* Per 1,000 annual exposures

† On an annual basis

TABLE VI

Discharges among first admissions with dementia praecox to New York civil state hospitals, fiscal years 1943–44 to 1946–47 inclusive, within two years after admission, classified according to condition at discharge

CONDITION AT DISCHARGE	MALES			FEMALES			TOTAL		
	Number	*Percent of total discharges*	*Percent of total admissions*	*Number*	*Percent of total discharges*	*Percent of total admissions*	*Number*	*Percent of total discharges*	*Percent of total admissions*
Recovered	607	22.6	11.9	1,224	31.4	16.3	1,831	27.8	14.5
Much improved	1,043	38.8	20.4	1,572	40.4	20.9	2,615	39.7	20.7
Improved	741	27.5	14.5	809	20.8	10.8	1,550	23.5	12.3
Unimproved	300	11.1	5.9	289	7.4	3.8	589	8.9	4.7
Total discharges	2,691	100.0	52.7	3,894	100.0	51.8	6,585	100.0	52.2
Total first admissions	5,107	–	–	7,520	–	–	12,627	–	–

of 11.9 and 46.8 for the current male cohorts. Similar improvements are found among females. Thus only 1.2% of the female cohort of 1909–10 was discharged as recovered within two years and a total of 13.0% showed some degree of improvement. The corresponding percentages for the current female cohorts were 16.3 and 48.0 respectively. The differences are so great that they cannot be explained away on the ground that the statistics for the early cohorts included readmissions.

As with rates of discharge, the statistics for degrees of improvement may be challenged on the ground that different standards of diagnosis may have prevailed in 1944–48. The latter, it is said, now include as cases of dementia praecox many who were formerly diagnosed as manic-depressive. If true, this must introduce a spurious element. Therefore it is desirable to make comparisons of combined groups of first admissions with dementia praecox and manic-depressive psychoses during the two periods. On this basis the results were as follows: Of the male cohort of 1909–10, 18.1% was discharged with some degree of improvement. For females the corresponding percentage was 16.0. For the current cohorts, however, the combined percentages were 54.2 for males and 50.6 for females. The conclusion is inescapable, therefore, that first admissions with dementia praecox now show rates of improvement three times greater than those that prevailed four decades earlier.

MORTALITY

First admissions with dementia praecox had low rates of mortality. Only 5.3% of the male cohorts died within five years after

hospitalization, compared with 39% of all male first admissions. Almost half the mortality occurred during the first year. More than half the deaths within this period occurred during the first three months.

Of the female cohorts 5.2% died within five years after hospitalization, compared with 36% of all female first admissions. As with males, almost half the deaths among females occurred during the first year. More than half the deaths during the first year occurred during the first three months.

Of the male cohort of 1909–10, 6.5% died within five years (5), compared with 5.3% of the current male cohorts. Of the female cohort of 1909–10, 11.3% died within five years (5), compared with only 5.2% of the current cohorts.

As with discharge, we may remove some possible ambiguities by considering mortality among combined groups of first admissions with dementia praecox and manic-depressive psychoses. Of the male cohort of 1909–10, 7.0% of those with the combined diagnoses died within five years after hospitalization. Of the female cohort of 1909–10, 11.3% died during this period. For the current cohorts the corresponding percentages were 5.7 and 5.3. We conclude therefore that mortality among current groups of first admissions with dementia praecox is definitely less than that which prevailed four decades ago.

The rates of mortality per 1,000 annual exposures are summarized in Table VII. Males began with an annual rate of 53.8 during the first three months. The rate of mortality decreased during the remainder of the first year of hospitalization to a minimum of 11.4 during the final quarter. The average rate for the first year was 25.5. The rate decreased to 13.3 during the second

TABLE VII

First admissions with dementia praecox to New York civil state hospitals dying during specified periods after admission, classified according to percentage and rate

PERIOD OF HOSPITALIZATION	MALES			FEMALES		
	Per-cent	*Cumula-tive percent*	*Rate per 1,000 exposures* *	*Per-cent*	*Cumula-tive percent*	*Rate per 1,000 exposures* *
First three months	1.3	1.3	53.8	1.6	1.6	67.4
Second three months	0.5	1.8	22.0	0.5	2.1	18.8
Third three months	0.4	2.2	18.0	0.2	2.3	11.3
Fourth three months	0.2	2.4	11.4	0.2	2.5	11.5
First year	2.4	2.4	25.5	2.5	2.5	26.8
Second year	0.8	3.2	13.3	0.7	3.2	11.0
Third year	0.6	3.8	15.1	0.7	3.9	16.4
Fourth year	0.9	4.7	24.4	0.7	4.6	18.0
Fifth year	0.6	5.3	18.6	0.6	5.2	15.8

* On an annual basis.

year but fluctuated irregularly during the remaining years, though at a lower level than during the first year.

Females began with a mortality rate of 67.4 during the first three months. The rate was reduced steadily to a minimum of 11.5 during the final quarter of the first year and averaged 26.8 for the year, compared with 25.5 for males. The rate declined to 11.0 during the second year. As

TABLE VIII

*Rates of mortality * among first admissions with dementia praecox to New York civil state hospitals during specified periods after admission, classified according to age at first admission*

AGE AT FIRST ADMISSION (*years*)	*1st three mos.*†	*2nd three mos.*†	*3rd three mos.*†	*4th three mos.*†	*1st year*	*2nd year*	*3rd year*	*4th year*	*5th year*
					MALES				
Under 15	–	–	–	–	–	–	30.8	45.4	–
15–19	15.3	10.9	5.7	–	7.9	10.6	13.1	11.6	–
20–24	55.7	12.2	12.8	–	19.9	6.2	–	–	–
25–29	40.2	–	22.4	–	15.2	10.4	14.0	–	15.4
30–34	35.9	25.4	8.8	18.0	21.2	2.0	4.6	55.8	19.6
35–39	55.8	53.9	5.6	17.2	32.0	7.3	20.7	–	–
40–44	67.7	19.4	13.2	26.6	30.8	22.9	25.4	43.2	48.8
45–49	122.5	40.1	10.2	30.9	50.0	17.1	34.6	32.5	–
50–54	72.5	45.4	46.3	–	39.8	24.0	11.0	–	43.4
55–59	24.8	25.1	126.6	26.3	49.5	59.1	18.0	119.4	160.0
60 or over	271.2	37.3	113.2	9.8	112.1	76.9	25.6	41.7	–
					FEMALES				
Under 15	53.3	–	–	–	13.2	–	–	–	–
15–19	22.4	6.0	–	–	7.2	8.5	–	13.3	–
20–24	56.4	9.6	3.3	3.4	18.1	6.1	18.6	–	14.4
25–29	40.7	13.6	5.6	5.7	16.1	7.4	8.5	10.2	10.9
30–34	56.2	13.5	11.1	8.5	21.9	10.8	16.4	36.2	21.2
35–39	53.3	26.5	21.0	3.1	25.4	6.5	14.0	9.3	10.2
40–44	11.1	18.0	9.1	9.2	36.3	20.8	18.2	12.4	14.9
45–49	92.2	19.2	–	26.3	34.0	2.8	4.9	15.2	13.5
50–54	128.4	19.3	19.6	9.9	43.5	19.3	14.4	23.1	21.7
55–59	148.9	15.7	47.2	80.2	70.9	24.6	42.8	16.7	–
60 or over	179.5	103.3	53.7	92.4	103.7	46.5	73.7	36.4	88.9

* Per 1,000 annual exposures

† On an annual basis

with males, the rate of mortality among females fluctuated irregularly from the third to the fifth years of hospitalization, though at a lower level than that of the first year.

The rates of mortality among the male cohorts of 1944–48 did not differ significantly from those of the males of 1909–10 (6). During the first year, which was crucial, the rates were 25.5 and 26.3 respectively. Among females, however, the rates were definitely higher for the early co-

TABLE IX

*Rates of mortality * among first admissions with dementia praecox to New York civil state hospitals during specified periods after admission, classified according to duration of mental disease before admission*

DURATION OF MENTAL DISEASE BEFORE ADMISSION	*1st three mos.†*	*2nd three mos.†*	*3rd three mos.†*	*4th three mos.†*	*1st year*	*2nd year*	*3rd year*	*4th year*	*5th year*
					MALES				
Under 1 month	105.5	17.7	18.3	12.5	37.5	37.5	43.6	27.2	–
1–3 months	60.2	11.6	17.8	12.1	24.8	4.1	–	22.3	–
4–6 months	65.7	24.0	8.4	8.6	26.4	7.4	–	–	–
7–11 months	14.4	–	16.4	–	7.5	7.3	–	27.4	–
1 year	34.4	7.3	7.6	7.8	14.0	9.8	31.6	14.7	–
2 years	10.2	10.9	22.8	23.3	15.7	11.0	11.4	–	44.4
3 years	19.3	40.6	–	22.4	20.0	8.8	16.7	–	–
4 years	–	34.5	–	–	8.3	–	–	–	–
5 years or over	27.8	48.9	30.6	10.4	28.0	12.6	7.4	25.4	–
					FEMALES				
Under 1 month	126.3	7.3	26.3	11.4	42.0	15.9	20.5	36.5	–
1–3 months	76.1	20.1	6.9	5.2	26.8	11.0	7.8	17.2	13.4
4–6 months	25.4	13.6	14.1	4.8	14.0	10.4	18.4	25.2	20.2
7–11 months	56.7	10.2	–	10.5	19.1	13.8	–	–	88.9
1 year	30.3	13.6	13.9	23.6	19.8	7.7	11.4	6.4	–
2 years	36.7	7.7	7.9	8.1	14.8	–	18.0	10.3	20.8
3 years	12.2	12.9	–	13.6	9.4	10.4	39.0	24.0	95.2
4 years	56.4	–	–	–	14.3	36.4	–	–	–
5 years or over	53.2	45.1	20.6	15.6	32.8	17.2	19.5	25.2	10.6

* Per 1,000 annual exposures.
† On an annual basis.

hort (6). The current female cohorts had an average rate of 26.8 during the first year, compared with 55.7 for the early female cohort. The rates were similarly higher for the latter cohort during the succeeding years of hospitalization.

If, as previously, we attempt to avoid differences that may be due to changes in psychiatric diagnoses and combine mortality for cohorts with dementia praecox with that for manic-depressive psychoses, we obtain results similar to those shown previously. Thus the average percentage of males dying within five years was 5.7 for the combined current cohorts, compared with 7.0 for the early cohort. Among females the corresponding percentages were 5.3 and 11.3 respectively. It may be concluded therefore that, as with discharges, definite improvements have been shown by the current cohorts with respect to mortality.

Table VIII shows a direct correlation between rates of mortality and age at first admission. During the first year of hospitalization the rate advanced from 7.9 per 1,000 annual exposures among males admitted at ages 15 to 19 to 32.0 among those aged 35 to 39 and continued to increase, with minor fluctuations, to a maximum of 112.1 among those aged 60 or over. A similar trend is apparent during the second year of hospitalization, the rate of mortality increasing with advancing age at first admission to a maximum of 76.9 among those aged 60 or over. Trends were similar for females. The rate increased during the first year of hospitalization to a maximum of 103.7 among those aged 60 or over. During the second and third years they rose to maxima of 46.5 and 73.7 respectively.

Table IX shows an interesting relation between the rate of mortality and the duration of the mental disease before hospitalization. It was shown, in the case of discharge, that the rate was higher among those with shorter histories of disease. The reverse is the case with respect to mortality. Those with longer durations prior to hospitalization have, on the average, lower death rates. During the first year of hospitalization male first admissions with a previous history of less than a year had an average mortality of over 20 per 1,000 annual exposures. Those with histories of more than a year averaged approximately 15. The trend is clearer among females, especially during the first year of hospitalization. In general, this is consistent with the facts disclosed in Table VII, where it was shown that mortality was high during the first year of hospitalization but decreased in succeeding years. As the disease reached a chronic state the death rate became stabilized at a lower level.

As a result of discharges and deaths the cohorts were reduced steadily in number. The rate of reduction is summarized in Table X. After three months of hospitalization the male cohort was reduced to 91.3% of the original total. This declined to 82.0% at the end of the first year. This was reduced by almost half to 43.8% at the close of the second year of hospitalization, a consequence of termination of convalescent care during this period. The number of patients remaining on the books decreased slowly after the second year. At the end of the fifth year 30.2% were still on the books.

Females decreased at a slower rate than males. At the end of the first year 85.7% were still on the books, compared with 82.0% of males. The percentage dropped rapidly during the second year to 44.9%. The percentage decreased slowly to 34.9 at the end of the fifth year, compared with 30.2% for males.

TABLE X

Percent of first admissions with dementia praecox to New York civil state hospitals, remaining in continuous residence at the end of specified periods after admission

END OF	MALES	FEMALES
Third month	91.3	92.8
Sixth month	86.6	88.9
Ninth month	83.9	87.0
First year	82.0	85.7
Second year	43.8	44.9
Third year	36.4	37.8
Fourth year	32.6	35.4
Fifth year	30.2	34.9

The median duration on the books was 22.1 months for males and 22.5 months for females. The tendency towards chronicity is shown by the fact that only 16.4% of the total male cohorts were still on the books at the end of five years and that the median duration was only 15.5 months. For total female first admissions the corresponding data were 19.4% and 17.6 months respectively.

The preceding data were based upon continuous histories on the books of the New York civil state hospitals. If we consider readmissions then the percentages of the current cohorts remaining at the end of five years were 40.4 and 46.6 for males and females respectively. The corresponding percentages for the cohort of 1909–10 were 51.5 and 56.5 for males and females respectively (7). The more rapid decline in recent years in the percentage of patients with dementia praecox remaining under treatment after five years must be attributed primarily to the higher current rates of discharge.

To complete the type of comparisons shown previously we may again combine the cohorts with dementia praecox and manic-depressive psychoses and derive the weighted percentages for both groups who were on the books after five years of hospitalization, including readmissions. Of the current cohorts 37.8% of the males and 43.2% of the females were still on the books. The corresponding percentages for the cohorts of 1909–10 were 47.6 and 52.8 for males and females respectively. Again it is clear that the better results for the current cohorts cannot be attributed to fashions in diagnosis.

SUMMARY

We may now summarize the data with respect to discharges and mortality among first admissions with dementia praecox to the New York civil state hospitals. The data consisted of five cohorts of such first admissions during five successive fiscal years beginning with the year ended March 31, 1944.

Of the male cohorts an average of 65.5% were discharged from the books within five years after admission. This may be com-

pared with an average of 42% for all male first admissions. The second year was the period of most rapid discharge because of the culmination of convalescent care during this period. Of the total approximately 45% left the hospitals within a year, either by direct discharge or by placement in convalescent care. This figure reduces to 40%, if correction is made for those who returned to the hospitals during this period. The corresponding percentage for a male cohort admitted during 1909–10 was 22.7. A total of only 34.5% was discharged within five years. Discharges among the current male cohort were therefore in significant excess.

Of the female cohorts 62.7% were discharged within five years after admission, compared with 43.5% of all female first admissions. As with males, most discharges among females occurred during the second year because of terminations of convalescent care. Of the total admissions approximately 40% had left the hospitals during the first year, either by direct discharge or by placement in convalescent care. When corrected for readmissions this figure reduced to 35%. The corresponding percentage for a female cohort admitted in 1909–10 was only 14.3. This grew to only 25.3% for the period of five years. Clearly, therefore, the probability of discharge has grown significantly in recent years.

There has been a similar increase in the percentage of patients discharged as recovered or improved in some degree. Within two years after hospitalization 11.9% of the first four male cohorts were discharged as recovered and 46.8% showed some degree of improvement, including recovery. A male cohort of 1909–10 showed corresponding percentages of only 2.0 and 14.8 respectively. The current female cohorts showed 16.3% discharged as recovered and 48.0% discharged with all degrees of improvement. Corresponding percentages for the early female cohort of 1909–10 were 1.2 and 13.0 respectively.

Mortality was low among the current cohorts of first admissions with dementia praecox. Only 5.3% of the males died within five years after hospitalization, compared with 39% of all first admissions. Of the male cohort of 1909–10, 6.5% died during an equal period. Of the current female cohorts 5.2% died within five years, compared with 11.3% of the female cohort of 1909–10.

In all respects, therefore, the current cohorts of first admissions with dementia praecox showed better results than their predecessors of 1909–10. Discharge rates and percentages of recovery and improvement were higher and mortality was lower. Some critics have argued, however, that these results are spurious in some degree because of changes in criteria of diagnosis as between dementia praecox and the manic-depressive psychoses. This was tested by weighting the proportion of these two groups of mental disorders in the same degree as the cohorts of 1909–10 and computing rates of discharge, *etc.*, for the combined groups. It then appeared that the current cohorts still showed higher rates of discharge and lower rates of mortality, thereby confirming that the current cohorts responded better as a result of modern methods of therapy.

Primarily as a result of discharges, the percentage of the male cohorts remaining continuously on the books was reduced to 82.0% of the total at the end of one year of hospitalization. As a result of the increased rate of discharge during the second year the percentage was reduced to 43.8 at the end of that period. At the end of the fifth year the percentage was reduced to 30.2. The corresponding percentages among the current female cohorts were 85.7, 44.9 and 34.9 respectively. If we take account

of readmissions then the percentages still on the books after five years were 40.4 and 46.6 for males and females respectively. Corresponding percentages for the cohorts of 1909–10 were 51.5 for males and 56.5 for females.

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1. Raymond G. Fuller, "Expectation of Hospital Life and Outcome for Mental Patients on First Admission," *Psychiatric Quarterly*, 4 (April 1930), 312.

2. *Loc. cit.*

3. Rates of discharge computed from data in reference 1.

4. Computed from data in Raymond G. Fuller, "Hospital Departures and Readmissions among Mental Patients during the Fifteen Years Following First Admisson," *Psychiatric Quarterly*, 4 (October 1930), 653.

5. See reference 1, 306.

6. Rates of mortality computed from data in reference 1, 306.

7. See reference 1, 301.

8. Computed from data in reference 4, 654.

Book Reviews

EDUCATING SPASTIC CHILDREN

By F. Eleanor Schonell

New York, Philosophical Library, 1956. 242 pp.

This book treats of the educational problems and evaluation of the educational difficulties arising from the cerebral palsy.

The book is divided into four parts.

The first gives a general definition and classification of the various types and causes of cerebral palsy. A history of the growing interest in the condition describes the progress, especially in America, Australia and Great Britain, in managing it.

Part 2 is concerned with the various surveys especially related to the Birmingham research project. The use of various scales in measuring intelligence in the cerebral palsied is described, and estimates of intelligence as carried out by many surveys in the different countries are compared.

Part 3 deals with practical planning of educational facilities for these children, and gives actual and suggested curricula.

Part 4 deals with psychological and social development, taking into consideration the limitations imposed on the cerebrally palsied child by his handicap.

This book is a valuable and well written source of information much needed by teachers and all others dealing with the psycho-social development of cerebrally palsied children. It should stimulate far better understanding and facilities for education of these children.

The only criticism that can be made of this book, in my opinion, is with regard to the title. The term "cerebral palsy" has practically superseded "spastic paralysis" when used for the whole group in America, and the same change is occurring more and more in Great Britain. The author mentions in her preface that she is using "spastic" to include the whole group. However, because of the confusion which has arisen from using this term except specifically for spastics, "cerebral palsy" is being more widely used now.—WINTHROP M. PHELPS, M.D., Baltimore.

PERSONALITY, STRESS AND TUBERCULOSIS

Edited by Phineas J. Sparer, M.D.

New York, International Universities Press, 1956. 629 pp.

The role of personality and stress in tuberculosis has been widely studied by many investigators who have approached the problem from the viewpoint of their own special interests. Although some of the more recent studies have attempted a multidisciplinary approach, the profound difficulties which beset all investigations of this kind have been evident. Dr. Sparer has edited a book which undoubtedly represents the most complete and thorough coverage of the field to date.

The book is the outcome of a series of lectures presented to the staff of Memphis Veterans Administration Hospital by recognized clinicians and investigators and designed to give "the gist and tenor of contemporary thought, practice and research in the various fields interrelated with tuberculosis." Dr. Sparer, as editor, made "no attempt to unify the various views and approaches, deeming such unification premature."

The first of the book's four sections deals with fundamental physiological, endocrinological and psychological concepts. In-

cluded is an excellent review of the general adaptation syndrome by Dr. Hans Selye. It is in relation to the first section that this reviewer felt a sense of frustration in finding that so many of the authors had refrained from attempting to relate their subject material to the particular problem of tuberculosis.

The second section, on Clinical Applications, is intended to relate basic considerations to the area of the clinical approach. This is to a large extent successful, particularly in such chapters as Dr. Masserman's on the fundamentals of psychotherapy with special reference to respiratory disease. A welcome inclusion is two chapters devoted to the patient's viewpoint, something which in view of the professed holistic approach of many authors has received remarkably short shrift. Rehabilitation of the tuberculous patient and the problems of geriatrics and surgery are well covered.

The thorny problem of self-discharge is the primary subject of the third section. "The prevalence of such discharge against medical advice constitutes the greatest single obstacle to the control of tuberculosis in this country." It is appropriate then that the editor devote six chapters and a sixth of the book to this area. Calder, Lewis, Lorenz and Thurston suggest specific leads towards predicting which patients will leave against advice, and outline a useful method of dealing with these patients. The special problems of alcoholic and psychotic tuberculous patients are reviewed.

Finally, the editor and his co-workers present an outline of a psychosomatic program of a comprehensive service to hospitalized tuberculosis patients, which is designed to be adaptable and to have provisions for expansion and revision where indicated in different or changing settings.

Dr. Sparer's book should provide for the specialist in tuberculosis and for the members of ancillary groups working in the field a useful guide in their efforts to understand and deal with the complexities presented by the tuberculosis patient. Perhaps even more importantly it should provide for them the stimulus to intensify their own investigations in this fascinating and rewarding field.—E. D. WITTKOWER, M.D., Allan Memorial Institute, Montreal

TEEN-AGERS AND ALCOHOL A HANDBOOK FOR THE EDUCATOR

By Raymond G. McCarthy

New Haven, Yale Center of Alcohol Studies, 1956. 188 pp.

Adequate provision for proper alcohol education in the schools has always presented manifold problems to the instructor and teacher. Attitudes toward the use of alcoholic beverages are heavily charged with emotion, and vary in many parts of the country. The teacher, in presenting factual information, must contend with attitudes in the home or community which often vary from his texts and his own attitude. As a result, although most states have legislation calling for a minimum period of instruction on this subject, these varying attitudes have impelled many teachers to avoid dealing with it insofar as possible. Mr. McCarthy's book, however, offers techniques and guides which make possible unemotional and factual presentation of subject matter in a way which will not only stimulate the youthful mind but which also utilize some of the more effective techniques being developed today in the area of general instruction.

For years past, of necessity, teachers have had to concentrate on the physiological effects of alcohol in the body and in the brief

period allotted to point their emphasis toward the damaging and dangerous effects of any use of alcohol which may develop to the point of excess. It has only been in recent years, with the development of more knowledge concerning the effects of alcohol and the pattern of progression which develops into the disease of alcoholism, that the psychological and emotional factors involved in the use of alcohol have been pointed up. The fact of motivation in drinking is an all-important one and at last is being given proper consideration.

Mr. McCarthy's book includes a summary of existing evidence of attitudes concerning drinking practices, including the attitudes of young people of high school and college age. In the beginning chapters he outlines the pressures to which teachers and administrators may be subjected from various community groups. As he points out in a major premise, "Emphasis must be shifted from *the active drinking and its physical effects* to the *attitudes* prevalent within the community and *the motivations* underlying acceptance of drinking practices." He then delineates some of the attitudes and practices of young people that have been shown in recent surveys.

The book is particularly effective and interesting because a great portion of it involves a verbatim record of discussions by student groups (four high school classes, a college ethics class and an in-service teachers' training class), all transcribed from tape recordings. This clearly demonstrates the value of the discussion technique for handling emotionally charged and controversial subjects such as the use and effects of alcohol and attitudes with regard to drinking.

Behind the practical techniques and experiences which this book affords to the instructor there is, however, a major premise which is of importance to all persons concerned with mental health. Two quotations will bring out this point, which is implicit in Mr. McCarthy's approach: "The essential goal of all educational enterprises is to encourage the development of a maturing personality in the younger members of our society. Such individuals will be able to cope with personal and social problems as they arise. Frustrations and disappointments will be accepted as a part of life. Techniques and methods of resolving problems need to be learned. The school should provide for this opportunity. People who develop resilient, mature personalities have little need to escape from reality. Insofar as schools are able to achieve this goal, they will contribute to the prevention of problem drinking and alcoholism."

And again: "Information presented on request to many adult groups throughout the state is probably responsible to a great extent for acceptance of the program by the schools. It emphasizes parental responsibility, character development through proper guidance in the home and school and the important role education plays in helping resolve the quandaries of our youth and in pointing a way to happy living. In this connection, alcohol education has been instrumental in promoting the work of mental health in the school and focusing attention on the need for better emotional hygiene."

Mr. McCarthy's book provides a real handbook for the teacher who is concerned and interested in providing unemotional, factual material to his students and who desires to play a part in the development of good mental health among young people. It can be utilized by instructors in any course which is selected as the framework for the teaching of alcohol and alcoholism.
—Mrs. Marty Mann, National Council on Alcoholism

MEDICAL RESEARCH: A MIDCENTURY SURVEY

An American Foundation Publication

Boston, Little, Brown & Co., 1955. Vol. 1, 765 pp. Vol. 2, 740 pp.

This is a broadly conceived, carefully documented 2-volume review of the over-all problems of medical education and medical research. In the second volume research in the special fields of cancer, infertility, rheumatoid arthritis, cardiovascular disorders, rheumatic syndromes, tuberculosis, virus diseases, alcoholism and finally schizophrenia is reviewed in considerable detail.

The authors bring out the problems facing the medical schools very effectively. These are shortages in personnel for teaching and research. At present the staffs of the schools are not able to keep up with their primary responsibilities of teaching medical students and conducting their own research. Yet they are continually under the pressure of special demands from the community such as care for the aged and staffing rehabilitation programs. It is particularly clear that there are insufficient doctors in the schools to aid in improving mental hospitals and in staffing psychiatric outpatient clinics and rehabilitation services. It is also demonstrated that all private medical schools have insufficient endowment to maintain—much less stabilize —teaching and research programs. This is a serious deficiency because there is a clear correlation between endowment and duration of fundamental research. The authors imply, but do not sufficiently emphasize, that psychiatric departments are among the most poorly endowed departments in medical schools.

The most striking thing about this review is the contrast between the confident enthusiasm with which the research projects are presented for subjects like cancer and cardiovascular disorders as compared with the cautious, uncertain and rather gloomy approach with which schizophrenia is handled. It is revealed that there is a great deal of money available for all kinds of methods of approach to cardiovascular disease and cancer and that even some of the more far-fetched approaches in these fields are greeted with enthusiasm and are supported. There is very little questioning as to whether or not the hypotheses are useful or whether or not the results of the research may prove negative. In contrast, when schizophrenia is considered, the leads for approaching these problems seem to be uncertain, and one is left with the feeling that there is little direction to the research into this condition. It is also noteworthy that there is comparatively little money available for research in this field and that also there are few people concerned with research in schizophrenia.

The authors overlook the substantial financial contribution made by the Supreme Council, 33rd Degree Scottish Rite Freemasonry, Northern Masonic Jurisdiction, to research in schizophrenia over a period of 22 years. The value of this book would be greatly enhanced by a good index, which would help in checking for important omissions such as this.

The authors refrain from making a summary or offering suggestions as to how to remedy the weakness of research in schizophrenia and other areas pertaining to mental disorders. However, a rereading of Volume I will reveal that they have emphasized that full-time staffs with adequate endowments lead to improved teaching and later to development of good fundamental research. This leads to the conclusion that an essential step in improving research in schizophrenia and other forms of mental illness lies in increasing the endowments of

departments of psychiatry in medical schools.—E. F. GILDEA, M.D., Washington University School of Medicine

PHYSIQUE AND DELINQUENCY

By Sheldon and Eleanor Glueck

New York, Harper & Brothers, 1956. 339 pp.

Should anyone doubt that physique plays a role in delinquency, Sheldon and Eleanor Glueck will impressively dispell such a doubt. The Gluecks have not attacked the Gordian knot of delinquency with an Alexandrine stroke but by a most painstaking check-counter check methodology so that unraveling delinquency is a far more appropriate phrase to use in describing their work, which has now reached monumental proportions.

The "Arithmetic Boys" will likely be more responsive to the Glueckian evaluation of the correlations between their various groups of anthropometric data and those dealing with behavior than perhaps those of the Sheldonian school. Nevertheless it is exciting to read that 60% of delinquents proved to be mesomorphic as compared with 12% to 14% respectively of the endomorphic and ectomorphic and balanced somatotypes and also to recall Sheldon's emphasis upon the north-northwest section of his somatotype chart in the direction of comparable findings. Sheldon's keen biological subjectivity as to the discernment of relationships between bodybuild and behavior may thus be reviewed with fresh interest. The work of Rees and Eysenck, Kretschmer and many others extending into the early explorations of mankind in this direction should be re-studied in this widening of the field of constitutional medicine.

The Gluecks have pointed out facts concerning physique and delinquency too numerous to mention here but it is fascinating to think over a number of observations such as the following:

Mesomorphs are more highly characterized by traits particularly suitable to the commission of acts of aggression (physical strength, energy, insensitivity, tendency to expression of tensions and frustrations in action together with a relative freedom from such inhibitions to anti-social adventures as feelings of inadequacy, marked submissiveness to authority and emotional instability).

Adventureousness in mesomorphs is more dramatic and exerts more socially disastrous effects than in endomorphs and ectomorphs.

Endomorphs and ectomorphs have lower delinquency potentials than mesomorphs. Endomorphs have more of a tendency to submit to authority and their energies are inconsistent with enterprise and daring required for delinquency; they also exhibit more of a tendency to conventional modes of thinking and behaving. Ectomorphs show a greater deficiency in the energy and drive for vigorous motor life. This is coupled with an excess of such curbing traits as a tendency to phantasy, emotional instability, emotional conflict and feelings of inadequacy; ectomorphs bottle up aggressive drives. The over-reactivity in terms of delinquent behavior of the ectomorph to the pressures and tensions of family life is a major finding.

Not for one moment do the Gluecks underrate environmental and cultural influences. Adverse interpersonal, familial and neighborhood influences may be the basic reasons for delinquency in many instances. Like William Sheldon, they say, however, that in many instances the possession of certain constitutional traits makes the person more vulnerable to the pressures and tensions of life and that the presence of

mesomorphic elements may predispose the person to acts of delinquency when adverse cultural factors take the initiative.

Sheldon and Eleanor Glueck go on to say in discussing physique and management that personality as a whole is involved and not in fragmental forms and therefore management should include reference to body build. In helping the delinquent child to readjust in the family, it is important to note that the ectomorph needs "extra" care and love and that the parents should be included in therapy. The endomorphic child needs to have new experiences of belonging, especially with the siblings, and the mesomorph needs vigorous and exciting outlets in socially constructive family activities.

The Gluecks stress the necessity of training teachers to understand the significance of body-build in the classroom. School curricula should be organized to meet the special needs of youngsters of different body types. Screening devices would help in the study of traits and socio-cultural factors especially as to prediction of the development of antisocial behavior in the different somatotypes. Teachers and consultants should understand the excessive sensitivity of ectomorphic children, etc. A great need exists for young adult male teachers even in kindergarten and early grades. Husband and wife teams could provide a warm emotional climate. Forcing all types of children into a single academic world is likely to result in increased tension, frustration and revolt. There is a need for a diversification of school activity so that the greater strength and uninhibited motor response to stimuli in the mesomorphs may find constructive outlets. Curricula should also take into consideration the greater submissiveness, sensuousness and conventionality of the endomorph and the greater aestheticism, feeling of inadequacy and emotional instability of the ectomorph. These facts are of great importance in the treatment and training of those boys and girls already delinquent.

It is interesting to note that the fourth somatotype—balanced somatotype—seems to be characterized by being at mid-center somatotypically and with an emphasis toward one of the other poles depending upon constitutional combinations. Apparently, though, the delinquency rate falls somewhere in the 12% to 14% range. This pattern is not clearly defined.

The Gluecks stress that there is no unitary cause of delinquency or single theory of delinquency. Their findings are a must for all serious students of delinquency. This volume should be studied widely and especially in teacher-training institutions.—EDWARD J. HUMPHREYS, M.D., Pennsylvania Bureau of Mental Health Services for Children

WHAT WE LEARN FROM CHILDREN

By Marie I. Rasey and J. W. Menge

New York, Harper & Brothers, 1956. 164 pp.

When experienced educators, working with children, retain their freshness and sensitivity they can produce a book of this kind. At the Rayswift School these writers (professors of psychology and education at Wayne University) have lived with and taught 54 children who embody a variety of emotional and physical handicaps. They have apparently been able to give strength and direction to the children while they in turn have learned from them. "The children have been our teachers as we watched their behavior, were party to their decision-making, and began to understand the values which released the selves they are into purposive action."

These writers' belief that other teachers may learn from their experience seems well-founded. The book contains perceptive descriptions of children, thoughtful statements about efforts to weigh and select educational procedures, and much beautiful writing. The latter is a welcome dividend in educational literature.

The first chapter, We Revise Our Assumptions, takes a clear look at learning, experience and value judgments in terms of the on-goingness of life, "the interrelation of the organism with its externality of things and people." What has been and what is being done by an individual child is considered not as an absolute but as a way to move on to better learning.

Chapters 2 through 4 (We See the Child in His Environment Differently, We Apply Revised Methods of Observation and Nurture, and We Analyze the Role of Purpose in Human Behavior) tell the story of life at Rayswift—the interaction between hurt children and a restorative environment. It is the vital life-stuff about eating, working, laughing, fearing, caring, problem-solving and growing.

The longest chapter, Some of the Children Who Taught Us, is not nearly long enough. The children are here, their language, their behavior as it changes and something of their histories. The authors have settled for luminous images that invite further study of the more intensive, carefully documented records. One assumes such records are in the files.

In the final chapter—titled How Shall We Educate?—the educators state their point of view. They look for total patterns in children, the relationship of energy to purpose to achievement. They recommend making individual circumstances of learning easy and feasible. Favorable attitudes and involvement are considered basic to learning. Finally, it is stated that children achieve better learning through cooperation than through competition.

What We Learn from Children is not a document of research in the usual sense. It is an original, independent little book about real experience, with its own flow of subjective responsiveness. It takes account of the feeling qualities of teaching. Herein lies its attractiveness and power in serving other teachers of children.—EVELYN D. ADLERBLUM, New York University School of Education

YOUR ADOLESCENT AT HOME AND IN SCHOOL

Lawrence K. and Mary Frank

New York, Viking Press, 1956. 336 pp.

This book is written for the use of parents, teachers, counselors and others concerned with adolescent boys and girls. It is based on a good coverage of the research in the field and on the wide personal and professional experience of the authors, who have dealt for years with young people and their families.

The writers discuss the current multiple impacts which give rise to the problems of today's adolescents as they and their parents meet a rapidly changing culture. There is discussion of the anxieties, fears and conflicts which exist on the one hand, but also of the possibilities for good and the opportunities which are present. Throughout the book there runs a constructive tone which expresses the conviction of the writers that "young people have many potentialities for coping with the tasks and problems of our day and that these potentialities need to be adequately developed and utilized by our schools and in our communities."

Especially helpful as an offset to some of

the writing of recent years is the nicely balanced discussion of love, which needs to be accompanied by discipline if it is to meet the developmental needs of children. Parents and educators, say the authors, are beginning to see that "normal" young people get into difficulty because the adults around them do not give the kind of help that is needed. "We feel that teachers, like parents, have made some mistakes—not in loving children and in giving them a chance to grow, but in taking for granted a strength in young people to stand up for right and just principles in their groups. . . . Boys and girls ought to know where the adult stands, where his convictions lie. . . . The acceptance by a good adult with some convictions about what is right and wrong for today's world is one of the biggest needs of every adolescent."

One of the main reasons for giving discipline is that it may become internalized in the form of self-control. When the young person has a certain measure of this type of inner control the authors say: "The stimulating, creative force for the young adolescent is the discovery that control is inside one's self: I must live this life, judge my own acts, choose for myself. (And it is also the reason for fluctuating despair, helplessness, guilt.) Early adolescence is a time of new, important learning—learning the consequences of one's own acts, the 'good' consequences along with the 'bad.' It can be a period of tremendous ethical and creative growth, a period when adults are as important, with their fairness and generosity and respect, as they are for the school-beginner."

About the guilt feelings which too often accompany adolescence the authors say: "An adolescence spent fighting childish feelings of guilt, rage and helplessness is a waste of precious life-time when young men and women should be able to admire themselves for what they can do."

There is a very readable discussion of several of the basic principles of growth: "Development may mean strains and tensions"; "Normal development may be uneven"; "Development demands a new image of self"; "Normal processes (in growth) create individual problems." The most current facts about the physical growth of pubescence and adolescence are presented with special attention given to the wide individual and sex variations in the rate of growth and development. The discussion of early and late developers has a reminder to both parents and young people themselves that although the lag behind or the spurt ahead of one's group may seem to last forever "the time span of 10 years or less in which these adolescent body changes occur may seem short when viewed in the light of the many years ahead."

The discussion of the close friendships and the episodes of hero-worship which characterize early adolescence is a level-headed one and should do a good deal to place in perspective parental worries about homosexuality. On heterosexual development the authors say: "In the past 40-odd years adolescents have found many new opportunities for a variety of sexually stimulating experiences and for sexual intercourse—a situation which worries parents. . . . . Beginning adult sexual experience in the teens, when marriage in our society is many years ahead, creates innumerable personal and social problems. In trying to orient adolescents today we are discovering that the heavy hand of parental authority carries little weight. . . . We are realizing that it is often more fruitful to talk to young people about what they want, what they hope to be, what images of themselves they cherish. Then they can consider their actions in terms of what they do not only to other people but to themselves, to their own dignity and worth."

Although the book centers largely on family relationships, chapters 9 through 12 are devoted to a survey of the kind of education adolescents need and to certain aspects of contemporary high school education and guidance. There is an excellent bibliography, an appendix on college information and a fine index.—LEE VINCENT, Chatham College, Pittsburgh

DEVELOPMENTAL PSYCHOLOGY

By Louis P. Thorpe and Wendell W. Cruze

New York, Ronald Press, 1956. 670 pp.

In their preface the authors state, "This is a textbook for the course in developmental psychology or human growth and development with a talk in the department of psychology, in the department or school of education or in home economics. It presents the essential concepts, research findings and interpretations upon which an abjectively derived developmental psychology must be based."

In general, this is a pretty accurate statement. The book covers such diverse areas as prenatal influences, moral development and juvenile delinquency, mental hygiene of the developing individual, and senescence. Its coverage in each area is broad. For example, in the chapter on the dynamics of human behavior the authors discuss the instinct theory, the concept of fundamental needs, the basic needs of the human individual, the psychology of frustration, autocorrectivism and homeostasis, the principle of economy of behavior, Freud and the sex drive, Adler and individual psychology and the Jungian school of psychoanalysis. There are such refreshing materials as a table showing the frequency, duration and rate of resolution of adolescent boy-girl affairs. The book is replete with a series of exercises or questions after each chapter and covering some of the material in the chapter.

In the reviewer's opinion this text is an extremely valuable contribution. It is well written and covers the field in a way that no book on child development has. It has enough material in areas in which the average college student has questions and interests about himself so that it should be very popular with college students. Yet it is also a volume which should be useful and interesting to many mothers to whom it should be anxiety-allaying rather than anxiety-creating.—LESTER W. SONTAG, M.D., Fels Research Institute for the Study of Human Development, Antioch College

PREFACE TO EMPATHY

By David A. Stewart

New York, Philosophical Library, 1956. 155 pp.

In that public arena wherein is being carried on the struggle to forge a general theory that will include the art of therapy with the science of society, many voices are crying to be heard. Few of these advocates can have so unusual a background of experience as that of the author of this book. Dr. Stewart's early training was in the field of philosophy, but he is at present engaged in the practice of group therapy with alcoholic patients, as chief psychologist of a clinic. As philosopher he is not only a trained thinker but also more aware than most of us of the timeless issues and broad reaches of his topic; as therapist he is denied by experience in demanding interpersonal situations the luxury of the easy solutions of the armchair.

Dr. Stewart has come to value empathy as the process *par excellence* in the therapeutic relationship. He has then proceeded to de-

clare it the fundamental process in all fully personal experience, basic to ethics (which is always social) as well as to esthetics. He ties his thinking to that of Freud, quoting and then elaborating upon two brief references to empathy in his "Group Psychology and the Analysis of the Ego"—the first to the effect that it plays the largest part in our understanding of what is inherently foreign to our ego in other people, and the second to the effect that there is a path from identification through imitation to empathy. In Dr. Stewart's interpretation of these passages, in the course of development there is first the stage of primitive involuntary identification, followed by a stage of resistance, then a stage of voluntary imitation based on conscious good will and finally the stage of deliberate attempt to understand the other while respecting his right to develop freely as a person. This last is the stage of empathy. It is essential to reach it, because the other person is both like and unlike oneself and there is always the danger of denying him the right to be unlike oneself.

Dr. Stewart is adamant on the point that the process of empathy cannot be studied scientifically, since any imposition of controls has a hampering effect. In any case, empathy cannot be directly observed. Its chief criterion is what he calls interpersonal testimony—either the persons agree that they are communicating well or they don't. When they do, that's empathy.

All in all, this is an ardent performance—even to the point of being vexatious. But then that is the burden of the argument. To become a person, in the finest sense, one must overcome resistance and achieve respect for the other. This is an ethics of hard-won respect, rather than an ethics of love. It is tough-minded, hard-headed, "realistic." And it will always have the last word.—R. G. N. LAIDLAW, M.D., Toronto

THE TEACHER AS A GUIDANCE WORKER

By Ira J. Gordon

New York, Harper & Brothers, 1956. 350 pp.

After fifty years of existence the guidance movement and the specialized workers in guidance are struggling not only for professional status but even for their very existence. Not only that, but they are fighting a war of attrition on two fronts. On the one hand, school psychologists and school social workers, because of their specialized training and needed services, are in demand by schools and where school systems cannot afford these services as well as guidance staff the educational and vocational guidance services may be carried on by teachers, administrators or the social workers and psychologists. On the other hand, many schools, operating on the cliché "Every teacher a guidance worker," turn over the delicate job of student counseling to any teachers who happen to have a free period now and then, after an hour or two of "training" by the assistant principal.

The Teacher as a Guidance Worker is designed to lend aid and comfort to the school administrator who subscribes to the latter point of view. "Most guidance work must be done in the classroom, by teachers who possess the guidance viewpoint and incorporate it in their teaching and other relationships with students." Certainly there can be no quarrel with this viewpoint provided it is part and parcel of a rich, well-rounded counseling program supervised by specialists who not only help with children who present problems beyond the capacities of teachers to deal with but who also work closely with the teachers in the preventive work that must be done in the classroom. Although stating grudgingly that specialists are also necessary in schools, the author goes

all-out in substituting teachers for professional guidance workers, instead of developing a balanced program of guidance in which both play important parts.

This book is nevertheless an important one in the fields of education and guidance. It is a veritable encyclopedia, although a condensed one, of much of the current literature in child development, group dynamics and the dynamics of behavior. The experienced counselor will find it a gold mine of ideas and research results, all succinctly presented. The teacher or other reader not oriented in modern counseling methods may be confused by the wealth of material presented in insufficient detail, or misled to believe that human behavior is really very simple if one follows the many telegraphically expressed formulae for dealing with complex problems of human behavior. The reviewer counted no less than 50 lists of prescriptions for teacher-counselors to follow in order to do effective counseling. A few examples illustrate the nature of these lists:

6 steps for scientific predictions
7 steps for recording observations
7 steps for analyzing the standard test
16 hypotheses relative to child growth
12 questions to be answered by home visits
14 general principles of learning
10 steps in the "choice-enabling process"
9 ways of promoting the group process
6 steps in action research

The book is divided into three parts and nine chapters. Part 1 deals with the nature of guidance and the scientific approach to behavior; part 2 has four chapters on human development concepts; part 3 treats of the teacher as group worker, as counselor and as action researcher. The material is well organized and each chapter has an extensive and valuable bibliography. It is a compact volume, which should make it very useful for reference and for review by experienced guidance workers but hardly for teachers who have not had broad training in modern psychology, child development, group dynamics and related fields.—MORRIS KRUGMAN, New York City Board of Education

THE THREE FACES OF EVE

By Corbett H. Thigpen, M.D., and Hervey M. Cleckley, M.D.

New York, McGraw-Hill Book Co., 1957. 308 pp.

The dust cover describes this book as "the fantastic true story of a housewife who was three women in one body." This reviewer heartily concurs in the use of this phrase, for he found the story to be as described—fantastic. Although as a non-medical professional worker in the field of mental health he has encountered strange cases, the one that serves as the subject of this book tops them all.

The book deals with a case of multiple personality in a young mother who manifests three distinct personalities during a lengthy period of psychiatric therapy. As the account of her treatment unfolds, the reserved, inhibited patient who first came to the doctor suddenly changes into an assertive, provocative woman who believes that she is unmarried and childless. The complete dissociation of this second personality from the original one is incredible. Still later in treatment a third personality appears. The uncanny aspects of the situation then become most marked as this latest emergence is described, for she is able to sense the thoughts and she experiences the behavior of the other two. Her account of their activities is like a private detective's report except that the information is more complete than one could obtain just by trailing someone else. In this instance the

reporter was actually in the body of the other two and consequently was able to describe not only their actions but their emotional reactions as well.

This is a true case study written by two psychiatrists who describe their experiences with this patient during several years. The narrative includes a full account of physical and psychological studies and of their therapeutic handling of the case.

This reviewer will not attempt to deal with the diagnostic assumptions nor the steps in treatment which the psychiatrists followed. Rather he will consider this book on its merits as a medium for mental health education and comment on its ability to encourage better acquaintanceship of the public with the causes and nature of mental illnesses and their treatment.

In this light the book does show that the causes of emotional maladjustment are complicated and that their deep roots in one's past life lie far below the surface. One's behavior, consequently, results from emotions of which one is unaware, from feelings and experiences which are forgotten, and from physiological idiosyncrasies. Another principle in mental health education that the book illustrates is that all human behavior has meaning even though its purpose and meaning may be obscure. The person who shows signs of emotional disturbance is letting others know that he is troubled and ill and that his illness represents his way of dealing with problems that are too confusing, too painful or too demanding. The book also points out very vividly the infinite patience that is required in treating emotional disorders.

These concepts stand out clearly and serve to orient the lay persons for whom this publication was apparently written to some aspects of mental illness.

Many readers may view this publication as a science fiction account, for it does have this kind of impact owing to the writing style and to its particularly astonishing subject matter. This fascinating aspect of the book may help to enhance its educational value.

A major fault is the authors' criticism of psychiatric and psychological theories propounded by others. Although the writers attempt to disprove these theories by indicating that in many instances they are based on conjecture, their own method was similarly based on no clear-cut understanding of the problem nor on a specific formulation of a treatment method. The authors might have acknowledged without disdain that there is more than one way of understanding a patient's illness and that adherence to a special theory need not interfere with successful treatment. Although at the present time there is no universally accepted theory of psychiatric or psychological treatment, all ethical workers have a common objective in seeking to bring about a lessening of their patients' suffering through an understanding and non-judgmental relationship.

This attack on other methods of therapy minimizes some of the values of this book as a mental health educational device, for it dispels confidence in those pioneers who, while groping with uncertainty and speculation, develop therapeutic methods which in later years become our orthodox treatment procedures.—EDWARD LINZER, National Association for Mental Health

TREATMENT OF THE CHILD IN EMOTIONAL CONFLICT

By Hyman S. Lippman

New York, McGraw-Hill Book Co., 1956. 298 pp.

In spite of the already existing literature on child guidance clinics, Dr. Lippman's book will definitely fill many needs. It combines the author's breadth of experience, his deep

understanding and interest in people with a wisdom which enables him to use language everybody is able to understand. His scientific concepts stressed by his early work with Anna Freud and Aichhorn have never led him into dogmatism.

Dr. Lippman gives a good picture of the basic trends in child guidance clinics and child therapy. He seems convinced of the value of the team approach and, like Freud, he comes to the conclusion that not only the physicians are experts in child therapy. In his own words: "The case worker who has been adequately trained to be a therapist and who devotes her time largely to the direct treatment of emotionally disturbed children is no longer acting as a case worker; she is now a therapist. . . . Both (the psychologist and the social worker) should have their therapy, whenever intensive, supervised by an analytically trained psychiatrist" (pp. 13 and 14). Dr. Lippman even feels that a psychiatrist working with emotionally disturbed children "can benefit from the experience of social case workers and clinical psychologists" (p. 14).

He describes the different categories of emotional disturbance which a child guidance clinic has to cope with and makes it clear why we need varying ways and lengths of time in our work. He considers flexibility, lightness and humor as essential factors for the process of therapy.

The case material illustrates very well Dr. Lippman's view about the therapist's task in a child guidance clinic. It demonstrates, for instance, how the therapist's knowledge of the child's unconscious conflicts gives him different possibilities of approach without ever verbally interpreting the child's castration anxiety (p. 122). The direct interpretation should be reserved for child analysis.

There are so many good points in this book that it is difficult to give justice to it in a short review. A few points will be mentioned briefly: The clarification of confusing definitions such as that for "acting out"; the recognition of the adolescent's need for help (in contrast to those who view adolescence as counter-indication for therapy); the importance of the family, which should be treated as a unit; the fact that foster homes are not unconditional answers for the emotionally disturbed child; the fact that small institutions with trained medical staff are much more necessary than acknowledged generally, etc., etc.

This book will be read with great pleasure by many workers from all the different professions, the experienced as well as the inexperienced. Those who are inclined "to explain behavior by theoretical mechanisms" may profit especially by the author's tendency to give life its right place without forgetting the theory.—LOTTE BERNSTEIN, M.D., Louisville Child Guidance Clinic.

STRAIGHT TO THE HEART: A PERSONAL ACCOUNT OF THOUGHTS AND FEELINGS WHILE UNDERGOING HEART SURGERY

By George Lawton

New York, International Universities Press, 1956. 347 pp.

These are days in which authors are bringing us closer and closer to the more intimate and dangerous aspects of life. To have health, man had first to face and understand the nature and cause of his illnesses and what to do about them. He had to learn to face tuberculosis, syphilis, poliomyelitis, cancer, mental illness, coronary occlusion and, now in this book, heart disease and its alleviation by surgery.

Here is a frank and revealing account of how one man and his wife (for the latter is not only mentioned throughout but writes

her own chapter) felt about it all. Their feelings and behavior are described before and during the operation. The reader is given an account of what factors entered into the decision for the operation—the pre-operation drama—the operation itself, the postoperative nursing care, the hospital atmosphere, as well as many other details.

This book differs from others in that it deals with the greater likelihood of death from this operation than from others.

From the time he can understand anything, a human being learns that the continued beating of his heart is necessary for life to continue. In a heart operation he faces the possibility that his heart may cease beating—and the possibility of sudden death is an awesome thing! Surgery always has its risks but none is so high and none so dangerous as one connected with this vital organ. And while death has always to be reckoned with in serious conditions, both medical and surgical, none brings so much threat and stimulates so many fantasies of sudden death in both patient and family as does heart surgery.

The patient-author, being an experienced and outstanding psychologist and not a new hand at writing books, has made this an interesting book and has tried hard to be truthful and to bring his readers face to face with the serious facts connected with heart surgery. This is an interesting personal story and will probably appeal to those who like stories of hospitalization and illness.

From the standpoint of mental hygiene one might ask if this is good reading for the prospective patient for heart surgery. While some of the content could be anxiety-producing there is abundant content that should allay anxiety. Some readers might be led to think, "I don't want heart surgery. I couldn't stand the serious implications of it—the fear surrounding it." But this does not mean they should not read this book. For is it not better to deal with fear (some of it at least) before hospitalization rather than having it all to deal with after the operation when everyone is busy and when, for his best welfare, the patient should not be burdened with too much fear? This reviewer would be inclined to let any prospective patient for heart surgery read this book and then deal with the anxiety provoked by it. This seems to be the best mental health procedure.

Readers may also ask, "Isn't it better that we do not always know what we are going to face and meet trouble when it comes—and *if* it comes?" This may seem sound and have some logic but again, considered from the standpoint of mental hygiene, a philosophy that helps people to face reality and get all the help available to deal with it is the only acceptable one. And that help —much of it at least—does not have to come from the specialist. The specialist in mental health has many functions and one of them is to show people that they have the strength to meet serious crises by making use of their already built-in mechanisms of courage and understanding and to teach them to reach out and trust what is available to them in their family, friends and personal physicians. This book helps them to do just that.—O. SPURGEON ENGLISH, M.D., Temple University

DISCUSSIONS ON CHILD DEVELOPMENT

J. M. Tanner, Bärbel Inhelder, eds.

New York, International Universities Press, 1957. Vol. 1, 240 pp.; Vol. 2, 271 pp.

Anyone interested in human growth or in the adaptations of human beings during

development will enjoy these proceedings of the two meetings of the World Health Organization Study Group on the Psychobiological Development of the Child. The aim of this study group, which met in Geneva in 1953 and in London in 1954, was described as "not the reading of papers, the passing of resolutions, or the issuing of a report, but the provision of an opportunity for mutual understanding to develop between workers in different disciplines, and on the basis of that understanding the attempt to relate the findings of one discipline to those of another and the hope that new research, and particularly joint research, might be undertaken."

Those readers who are familiar with the Macy Foundation conferences will feel at home with the method of conducting the discussions reported in these volumes since Dr. Frank Fremont-Smith served as chairman. The other members of the Study Group were John Bowlby, G. R. Hargreaves, Bärbel Inhelder, Konrad Lorenz, Margaret Mead, K. A. Melin, Marcel Monnier, Jean Piaget, A. Rémond, R. R. Struthers, J. M. Tanner, W. Grey Walter and René Zazzo. J. C. Carothers, E. E. Krapf and Charles Odier attended as guests. J. M. Tanner and Bärbel Inhelder, who served as editors, deserve credit for most satisfactorily accomplishing the difficult task of editing a free-wheeling discussion in such a manner as to make it fascinating reading.

In the 23 pages of the introduction to Volume 1 Dr. Fremont-Smith succeeds in getting each participant to give a brief autobiographical sketch. This serves somewhat the same purpose for the reader that it must have served for the participants, and increases his sense of participation in the discussions as they unfold. The remainder of the first volume is devoted to eight discussions. Brief comments about each may give the prospective reader some notion of the flavor as well as of the contents of this interesting volume.

In the first discussion J. M. Tanner presents his ideas on the physical and physiological aspects of child development. This reviewer found his description of physical growth fairly adequate but too standardized. Toward the end of the discussion Margaret Mead expressed her surprise that he "did not say anything to us about the individual differences." Considering how many exciting advances there have been in our knowledge in recent years I found myself disappointed by Tanner's inadequate covering of physiological aspects of growth. However, the discussions which follow contain much food for thought. The contributions of Conrad Lorenz and Frank Fremont-Smith were particularly thought-provoking.

The second discussion was led by Marcel Monnier, who described his studies of the behavior of new-born anencephalics with various degrees of anencephaly. Although the account of these investigations is interesting their interpretation may be and was promptly challenged. I enjoyed particularly the discussions of Grey Walter and Jean Piaget. The comments of Lorenz on the overlapping of instinctive actions and activities were also helpful.

Bärbel Inhelder started the third discussion with an account of Piaget's concepts of the stages of development. Her illustrations, with sketches, of the child's development of concepts of matter, of volume, of surface and of liquids, together with that of numerical correspondence and system of reference added greatly to the clarity of her presentation. In the discussion that followed stimulating questions were raised by almost every participant. Piaget then adds interesting comments of his own. In the second half of this discussion Lorenz precipitates a fascinating discussion by questioning the relation between a person's

power of abstraction or generalization and his particular ability to perceive complicated *Gestalts.* Inhelder, Piaget, Mead, Grey Walter, Carothers and Odier all join in a lively and entertaining exchange of ideas.

In the fourth discussion Konrad Lorenz describes his investigations under the title "Comparative Behaviorology." This is a delightfully clear presentation of such concepts as innate behavior, innate releasing mechanism, imprinting, gradations between true imprinting and the more common types of learning, and the like. Following the showing of a film illustrating some of these activities there was again a lively discussion involving most of the members of the study group. For this reviewer one of the most interesting interchanges was that between Lorenz and Mead on the disintegration of the innate releasing mechanism in illness and in domestication, resulting in a sort of vulgarization of responses.

Grey Walter takes over the fifth session with a discussion of electroencephalographic development of children. This impressed me as a rather mechanistic and overstandardized account. His linking of EEG characteristics with such psychological attributes as ductility, temper outbursts, versatility, stability, *etc.,* while fascinating theoretically seemed to lack adequate evidence. Questions were raised by nearly everyone present. The resulting discussion was lively but raised more questions than it answered.

The sixth discussion was initiated by René Zazzo on the stages of psychological development of the child. He attempts to compare the "psychologies" of Wallon, Piaget and Gesell. I found this chapter none too clear. The paucity of subsequent discussion also makes it less interesting although Inhelder's final summarizing of differences and similarities between Wallon and Piaget is worth reading.

John Bowlby leads the seventh discussion entitled "Psychoanalytic Instinct Theory." His discussion of Freud's concepts seems to the reviewer rather confused. His attempt at relating psychoanalysis and ethology is far from being adequate. His list of eight "propositions" of psychoanalysis seems not only trite but oversimplified. There follows a discussion of Freud, Piaget and Lorenz by Odier which seems only slightly better. Failure to make any mention of the tremendous part played by the unconscious impresses me as a strange omission. In the general discussion which follows the comments by Krapf, Lorenz, Odier and Hargreaves are certainly thought-provoking.

At the eighth session the group was shown films by Margaret Mead and Lorenz on a cross-cultural approach to child development problems. Mead discusses interestingly the role of culture in patterning the growing individual. She also expresses her expectation that we will find a large number of innate individual differences in every society. As usual she has many challenging statements and entertaining illustrations. A good example of the former is "thumb-sucking is absent in every group when the baby is fed by somebody within an hour of birth."

Konrad Lorenz's film was on the behavior of birds. There follows a long and stimulating discussion roaming over a wide area of concepts with nearly everyone in the study group participating. The liveliness of the discussion and the number of interesting topics considered make this an appropriate ending for Volume I.

In reviewing the first volume, I attempted to catch something of the atmosphere of the study group by describing briefly each of the eight discussions. Dr. Fremont-Smith conducted the second meeting in much the same way. For the six discussion sessions

the Study Group members were joined by Dalbir Bindra, D. Buckle, Howard Liddell and John Whiting as guests.

I found this second volume just as stimulating as the first. It is encouraging to see that investigators with such diverse approaches to problems of human development are able to exchange ideas so profitably and so pleasantly.

The report of the first presentation by Grey Walter together with the resulting discussion covers 55 pages. The major share of the presentation consists of possible mechanical or electrical models illustrating the six ways in which psychobiological development is said to occur. The models are fascinating, the interpretations and analogies less than completely convincing. In sharp contrast to this brilliant display of mechanistic explanations of human behavior is the second presentation by Dalbir Bindra. His description of dog and animal experiments in Hebb's laboratory at McGill leads to lively expressions of differences of opinion in regard to both the experimental design and the conclusions.

In the third discussion period Howard Liddell presents an account of his experimental studies of sheep and goats at Cornell University. This presentation and discussion cover 50 pages. The reviewer suspects this was less well edited than some of the other chapters. At any rate it is a little difficult to follow the thread through the maze of details to discover the implications concerning the production of neuroses. Again the following presentation by John Whiting is in sharp contrast. He introduces the notion of "learning without direct tuition" as being what is suggested by the "Freudian notion of identification and superego development." From his cross-cultural studies Whiting then develops a measure of "patient-responsibility" and suggests from his data that the earlier one's socialization training the higher the degree of responsibility for one's own actions. In discussing this and other factors related to patient-responsibility Whiting precipitates some of the liveliest and most stimulating discussion in the volume.

The fifth discussion centered around the film called "A Two-Year-Old Goes to Hospital" shown by John Bowlby. So many people have seen this film that it probably does not need to be described here. Suffice it to say that there were sharp differences of opinion in the study group as to how much little Laura, the 2-year-old, was hurt. Discussions of "good" or "bad" mother, of the nature of stress, of the part played by intelligent level, self-control, *etc.*, make interesting reading.

The sixth and final discussion centered around a film shown by Konrad Lorenz depicting behavior patterns in prematures, new-borns and some older infants up to one year of age. The observations are centered on the maturation of afferent control of spontaneous activity. Illustrations include breast-seeking as "oral prehensile reflex," the grasping reflex, *etc.* Many useful discussions followed the film presentation. In the latter half of this final discussion period Inhelder presented a fascinating description of learning experiments with children of 3 to 5 years, 9 to 11 years, and 14 to 15 years of age. Piaget added an unusually clear summarizing statement. Another lively discussion followed, involving all the participants in the study group. Appropriately enough the final discussion was philosophic. It was precipitated by a question put to Piaget by Lorenz, "Are you an empiricist or a-priori-ist?"—ALFRED H. WASHBURN, M.D., University of Colorado School of Medicine.

Editorial

There is a growing interest in the United States in the success abroad, especially in England, in maintaining unlocked wards in mental hospitals. This interest runs the range from enthusiastic approval to doubts and excuses as to why the idea cannot work here.

There have been many visitors from the United States to these open-ward hospitals in England. Recently New York State sent a delegation of six mental hospital superintendents to see the provisions for themselves, and unofficial visitors have come from other states.

Recently I also had this privilege. After general discussion with the superintendent of the hospital at Warlingham Park about his thinking on the matter of open hospitals, we were turned over to a patient shortly to be discharged, with instructions to him that we be taken anywhere we wished. Ward after quiet ward was visited, always with the same observation: There were no unpleasant odors. This is significant in view of the age of the hospital and the wooden floors with wide cracks between the floor boards. The patients were quiet and busy. One ward was found to be locked, but on opening it we found it was in good trim; no patients were there and we learned the ward was locked because patients tended to wander back into it.

The most disturbed male ward was set up with a habit-training program whereby patients are emancipated from soiling and wetting to a point where they can participate in many hospital activities, although they may not have made much basic psychiatric improvement. On a ward of 51 only about 10 had not been brought to this degree of improvement in behavior. Daytime sedation was practically non-existent and night sedation unusual. The destruction of clothing had greatly reduced over a 5-year period, dropping 50% in the replacement of pajamas and sheets.

The wards were comfortably and attractively furnished and showed no signs of damage or regimented sitting in rows. The occupational therapy department was a very busy place. A small pantry off to one side was used for preparing coffee or tea for the patients and many of the patients had cups of tea near them as they worked.

The mental hospital at Warlingham Park serves Croydon, a city of about 250,000. Since the hospitals of England are districted, it gives practically all of the mental hospital service that is rendered to that community, its patient clientele being comparable to that found in our state hospitals and veterans hospitals combined. It cares for about 1,100 patients. So well accepted has the hospital become in its community after some 15 to 20 years of enlightened administration that 90% of its patients enter voluntarily. That the progress made at Warlingham Park is not the result of special local advantages is evidenced by the fact that England has its share of unsavory hospitals comparable to many of our own—GEORGE S. STEVENSON, M.D.

Notes and Comments

MENTAL HEALTH WEEK

Reports from state and local mental health associations indicate widespread participation in the 9th annual observance of Mental Health Week April 28 to May 4. An upsurge of public concern over the problem of mental illness drew many thousands of citizens to rallies and special events.

Publicity also set new records both for quality and quantity as television, radio, newspapers and magazines threw the full weight of their resources behind the National Association for Mental Health and the National Institute of Mental Health, which co-sponsored the observance. Old Washington hands said the bell-ringing ceremony at the U. S. Capitol which launched the week attracted greater news coverage than any recent event except presidential news conferences. Newsreel, wire service and TV cameras recorded the scene on the Capitol steps as Vice-President Richard M. Nixon and Sen. George A. Smathers of Florida rang the historic Mental Health Bell. Their action set other bells ringing across the country as a signal to thousands of volunteer Mental Health Bell-Ringers to begin the annual campaign for members and funds for the National Association for Mental Health.

The bells sounded a new note of hope for 750,000 hospitalized mental patients as the nation rallied for action on their behalf. Hope was also the keynote of the Mental Health Week slogan: The Mentally Ill *Can* Come Back—Help Them!

Senator Smathers was chief sponsor in the U. S. Senate of a joint resolution calling on President Eisenhower to proclaim Mental Health Week. Rep. Dante B. Fascell of Florida co-sponsored the resolution in the House. The President signed the proclamation April 20 in Augusta, Ga.

Besides the National Institute of Mental Health, other federal agencies joined in the observance—plus state and territorial mental health departments, state and Veterans Administration hospitals and community mental health clinics. Backing up the 550 state and local mental health associations were affiliates of other major national organizations, including the U. S. Junior Chamber of Commerce, American Women's Voluntary Services, National Council of Catholic Women, American Legion Auxiliary, American Nurses' Association, Civitan International, Boys' Clubs of America, National Federation of Business and Professional Women's Clubs and National Catholic Community Service.

PSYCHIATRY AND THE LAW

The most effective time for psychiatrists to aid in the determination of justice for a mentally ill defendant is in the pre- and post-trial period, Dr. Philip Q. Roche, Philadelphia psychiatrist, said recently at the University of Michigan.

Delivering the last of a series of three Isaac Ray lectures sponsored by the American Psychiatric Association, Dr. Roche said psychiatrists should not be asked in court whether or not a crime committed by a person who is mentally ill resulted directly from his illness. In his opinion, psychiatrists do not belong in the courtroom except as resource persons ready to give scientific facts on request.

"A psychiatrist is not qualified to answer questions leading to moral judgments. That is a job for the jury," he asserted.

Psychiatrists, he pointed out, learn to think of a person's unconscious motivations. Lawyers, on the other hand, concentrate on clues, evidence, confessions and other fac-

tors. The differences in thinking and expression of the two professions can become particularly acute in the courtroom, Dr. Roche asserted. But this need not mean they cannot help each other outside. He said some of the conflict in methods and thinking between psychiatrists and lawyers might be modified in the universities by closer collaboration between medical students and law students, together with students in the other social disciplines.

The Isaac Ray lectures, held once a year at an outstanding university with both law and medical schools, bear the name of the first psychiatrist to establish the relationship between psychiatry and the law. Dr. Ray was also a founder of the American Psychiatric Association.

RESEARCH

A study by statisticians of the Metropolitan Life Insurance Company indicates that a considerable proportion of those policyholders who have suffered mental disorders severe enough to cause disability ultimately recover and are able to resume and maintain a "fairly normal level of activity." The study also indicates that the rate of recurrence of the disorders is relatively low and decreases as time goes on. The record of survivorship following recovery from disability is described as "comparatively favorable." The report points out that new and improved types of treatment of mental disease have been developed since the period covered in the study and that "the outlook for recovery and rehabilitation from mental disease has never been so favorable."

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Interviewers began May 6 to visit selected households throughout the nation to obtain information for a national health survey approved by the last session of Congress. They are asking questions about illness in the family, about accidents and injuries, disability, hospitalization, and medical and dental care.

The household interviewing—being done for the U. S. Public Health Service by the Bureau of the Census—will be carried on continuously. Each month a different group of 3,000 households will be visited. As the data accumulate they will begin to show health conditions throughout the country.

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University of Texas educational psychologists have launched a 2-year study to determine whether it is feasible for the public schools to include a program for mentally defective children.

CARE AND TREATMENT

Pennsylvania opened its first Children's Evaluation Center March 15 at the Philadelphia General Hospital. The center, a mental hygiene diagnostic clinic, provides outpatient facilities for children and adolescents requiring study and treatment.

Problems to be studied at the clinic include, among others, those associated with mental retardation, emotional instability and certain aspects of delinquency. Facilities will be available to handle a small number of resident patients. The center is staffed by psychiatrists, psychologists and social workers of the Eastern Pennsylvania Psychiatric Institute.

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Canada is establishing its first research center for mentally ill children in an Ontario hospital that once cared for convalescing polio victims—now few because of the dominion's Salk vaccination program.

NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Voluntary Promotional Agency of the Mental Hygiene Movement founded by Clifford W. Beers

OBJECTIVES: The National Association for Mental Health is a coordinated citizens organization working toward the improved care and treatment of the mentally ill and handicapped; for improved methods and services in research, prevention, detection, diagnosis and treatment of mental illnesses and handicaps; and for the promotion of mental health.
